

Canadian Journal of PUBLIC HEALTH

The National Journal of Preventive Medicine

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Number 9

THE OPEN DOOR HOSPITAL

Herman B. Snow

SEP 1958

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DENTAL DISEASE AND ITS RELATION TO PUBLIC HEALTH IN ALBERTA

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THE ROLE OF THE VOLUNTARY HEALTH AGENCY

Christian Smith

Program of Ninth Annual Meeting, Ontario Public Health Association

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Canadian Journal of **PUBLIC HEALTH**

VOLUME 49

TORONTO, SEPTEMBER 1958

NUMBER 9

The Open Door Hospital

HERMAN B. SNOW,¹ M.D.

"STOP that patient! Get him! Stop him!" The time—September 1954. The place—St. Lawrence State Hospital. The occasion—a patient had escaped from a locked ward and was running across the field.

At that time the hospital had a population of over 2,200 patients. There was a therapeutic program which included insulin, electric shock, psychotherapy and a good ancillary program of occupational and recreational therapy, not unlike many other hospitals. In many ways, the hospital was typical of the average institution, in other respects, just a little different. About 30% of the new admissions were on a voluntary basis and 60% certified; the others were criminal order cases and health officer emergency certificates.

At the end of 1954 only 155 men were on parole wards, that is, wards which were unlocked during the day so that patients could go to their work and return with a minimum of difficulty. During 1955 this number was increased to about 300, including 80 women, or about 13% of the population. These patients usually were the working patients who were well institutionalized and carefully selected, who helped in the laundry, or on the farm, or in other hospital industries, or with other routine duties. The increase in number of these patients made it easier for the nurses and attendants on those wards and it increased the working capacity and efficiency of the patient help because they got to their work quicker when the ceremony of the lock and key was dispensed with.

In other areas of the hospital, the restraint rate during 1954 had averaged 35–40 patients per day. About 75,000 aspirins were used in a year and sleeping pills occupied a very high position in the drug budget. Early in 1955 we began using Thorazine as the first of the tranquilizing drugs. In a few months, the restraint rate dropped remarkably so that by July and August it was down to 6–8 patients a day for the whole hospital. Patients became more amenable.

¹Director, St. Lawrence State Hospital, Ogdensburg, N.Y., U.S.A.

They could now be engaged in conversation and many more became interested in occupational therapy and recreation. However, by December of 1955 it was obvious that the restraint rate was rising again and had reached an average of 14 patients per day in spite of tranquilizers or other treatment or the increased ancillary programs. The patients were again becoming restless and slightly aggressive and the tension among patients began to mount. It was at this point, coincidentally and fortunately, that the open door mental hospital came to our attention through several channels but most important from Dr. Robert C. Hunt who had been to England and observed such hospitals. The writer was fortunate in receiving much firsthand information from Dr. Hunt who reported his experiences in, "Summary of Observations-Mental Health Programs in Britain and Holland 1956".

The first ward was opened July 1955, but only for 2 hours in the morning and afternoon. Here was a group of 60 women who had been in the hospital for over 5 years and some as long as 15, 20 or 30 years. Although neat and clean, they were the usual paranoid or hebephrenic schizophrenics. There was no formal training in regard to the open ward but the doctor and supervisor on the service were briefed in the ideas of the open ward to allow patients more freedom, even if they were not going to a specific place of work, but just for a walk, smoke or whatever they desired. The patients were at first almost as confused and apprehensive with their new freedom as the personnel were, but this gradually stabilized. Patients came and went; no one ran away. Somehow they managed to get back to the ward on time in accordance with the schedule. Soon the charge of the ward "forgot" to lock the door at the end of two hours and soon the supervising nurse did not call attention to this any longer. The door remained open during the lunch hour and then later and later in the afternoon until 6.00, 7.00 and then 8.00 p.m. It took several months to become accustomed to this new idea.

In January of 1956, the program of the open door really got under way. As each ward was opened, doctors, nurses and attendants and all personnel watched to see what would happen not only to the patients but also to the personnel themselves when all the anticipated escapes and injuries, such as patients getting lost in the woods or hit by a car or other injuries would occur. Wholesale escapes did not occur. Fights and assaults did not occur. People did not get lost in the woods. As each ward opened and remained so, the tension among patients and between patient and employee and among the personnel, began to decrease until its absence became very noticeable. It had been decided that a ward would not be considered "open" until it remained unlocked for at least 8 hours and the patient could go to the outside without interference or being questioned. As the wards were opened during 1956, the restraint rate began to decrease again and this time it stayed down until it was close to zero and has remained so to the present time.

Many incidents happened in regard to open wards. On one ward a patient on finding the door opened notified the attendant about it. The attendant told the patient that from then on the doors would stay open all day. At this moment the patient saw the supervisor nurse outside. She ran through the door and outside screaming to the supervisor that the charge attendant "had

gotten crazier than the patients, she wouldn't lock the door." In this manner we learned for the future. As the ward was to be opened, the patients were told henceforth they could go in and out as they pleased. The doors would be open from 7.00 or 8.00 a.m. to 6.00, 7.00 or 8.00 p.m., or later, depending on the ward and the age of the patients. One man who had been in the hospital over 20 years had been trying each door of his ward day after day, always trying to get past the attendant or nurse. He talked very little to anyone, just went intently about his business of seeing if each door was locked and if he could get through it. One morning he was told that he would not have to do this any more, that the doors would stay open all day and he could go out anytime he pleased. For a week he did not go near a door and could not be pushed outside. When a doctor asked him why he did not go out after trying so hard for twenty years, he accused the doctor of trying to get him outside and then not let him back in. He accused the doctor of trying to get rid of him so he could get his money in the business office. It took two more weeks to convince him this was not so. He would stand half inside and half outside the door and gradually he began to remain outside and walk about without any apprehension about getting back in.

One day, shortly after one of the wards was opened, a patient came back leading another one who had fallen down. When asked what had happened, he said they both heard a noise in the sky. They had heard of aeroplanes but could never see one from their ward. They got so excited looking at the plane flying that they forgot to watch where they were going and consequently one fell down. Another patient kept going to the parking lots and would try to sit in each car that was left open. We thought he was trying to escape. When he was questioned, he said he just could not imagine a car without the gear shift lever on the floor and would sit and stare at the new gear shifts. He was thrilled when an attendant showed him how it worked and gave him a ride. For many years the women patients who worked in the laundry were escorted by the attendants and laundry personnel to and from the laundry. Unfortunately (and yet fortunately!) a more than usual number of attendants took sick and some were on vacation and there was not enough help to take the patients to the laundry. Two patients stepped forward and said they knew the way and would get the 30 others over to the laundry. At the time these women were still on a closed ward. The supervisor let the group go unsupervised but watched from a distance. The patients got to the laundry on time every day and returned on time with no untoward incidents. Their ward was then opened and the laundry itself was never locked again. The patients now go in groups or pairs instead of being regimented. They leave the laundry to smoke or get some fresh air when they desire. The efficiency of the laundry never suffered.

When the program of the open ward started, there was a distinct drop in the occupational therapy program. Patients just kept walking about the grounds and would not attend the classes. This went on for about two or three weeks until the patients became accustomed to their new found freedom and oriented to the grounds of the hospital. They went through a period of exploration much the same as young children. Then they began to return to

the classes. They were allowed to come and go as they pleased. Soon the occupational therapy building was left open. Occupational therapy workers no longer went from their building to the ward to perform the ceremony of locking and unlocking doors to get the patients and return to the occupational therapy class where again everything stopped at 10.30 a.m. so that patients could be returned to the wards. Now the patients go to the class by themselves at 8.00 a.m. and stay there until 11.15 a.m. or later. The classes now are twice as long and almost double in size. During the year 1957, twice as many articles and twice as much money was realized from sales in this department than in any other year.

In the summertime, patients went out after their dinner but had nothing to do except sit around. Soon we began to leave baseballs, bats and gloves in a convenient unlocked place the patients could get at. They organized games among themselves. Student nurses and older children of the staff joined in the games. In the winter ice skating became a popular sport for many—on the ponds at the hospital which were frozen over—and skates were left in unlocked areas where patients could get them.

The wards began to undergo changes as the open door progressed to its present status of 100% of the patients in these areas. Patients slept better and ate better. From a large amount and a great variety, use of sedatives dwindled to practically nil. Strangest of all, possibly, was the drop in use of aspirin from 75,000 pills a year in 1954 to less than 5,000 in 1957.

Many of the patients now wanted to carry on conversations with the ward personnel and the doctors. They began to discuss problems. Nursing service changed. The nurses began to function again as psychiatric nurses, instead of watching the patients they began to talk to them. The nurse no longer ran to separate patients but rather to talk and find out what was troubling them. Sometimes this took the form of actually discussing a patient's illness and troubles which were referred to the doctors. More often, the nurses and attendants found out matters important to the patients which were a source of irritation. There were no mirrors to see their clothes. Now, almost all wards have a full length mirror. Men complained that the barber could not shave them often enough. They were encouraged to buy electric razors and shave daily; others in groups were given safety razors and allowed to shave themselves in the barber shop. Instead of women wearing dresses made of strong material, regular dresses were purchased. All this resulted from wanting to look well outdoors when in the company of others. Couldn't they be encouraged to do all this and still maintain the security of the locked door? Certainly! But how long can anyone be stimulated to do something when he can see no reason for it? We found, with the freedom of the open door, that many patients did not have to be encouraged or stimulated by us but that the stimulus came from within themselves. In the past, weather permitting, patients were taken out from closed areas in groups for a walk or to sit around in one spot, but with the liberty of the open door they could move around and talk to others. How many times do we hear in ordinary life that travel is broadening and how much good it does for us in many respects? Perhaps travelling from one building to another may not appeal to many of us

as a trip across country, but to many of our patients it took on such significance after their confinement. For this reason alone, trying to accomplish liberty and to encourage personal interest and behaviour behind a locked door does not quite get the same results as when the patient from within finds such interests necessary and desirous. It is a part of the social reorganization of the individual which we in many cases had disorganized with security measures—restraining and limiting relationships as well as dress.

Smoking had been a problem at our hospital as at many others. Smoking parties were organized when the work was done, when there was time, outside when the weather permitted, and when it did not—inside, in a crowded area. Is it any wonder our patients became irritable, tense and anxious? How many of us start smoking a cigarette even before finishing the last mouthful of food? Why should not our patients who have the same feelings have the same advantages? Why is it so strange that they would get tense, irritable, anxious and refuse to work if they did not get a cigarette? I have seen patients go to church services not for religion but just to get outside for a smoke before going into church. Here is another area where there is no longer any tension or concern. Patients smoke in the dining-room, where possible, and where it is not, they go outside and have their smoke. The attendant does not have to worry about the patients getting into a fight. The nurse does not have to hurry through something to get a smoking party organized.

Religion is a source of concern to many patients, more so than we realize, I think. People became discouraged as they waited behind the locked door for this one or that one to get ready—discouraged waiting to get to the clothes rooms which were locked—discouraged because they walked in a straight line to church—counted and herded to a pew and then returned to the ward in the same manner. I have seen people in the community get to church a half hour ahead of time. They like to sit in the front pew or the rear pew where they can watch what the other one is wearing or who he is with. Some like to go and pray in silent devotion for a while before the service or remain to chat with other people after the services—with the minister, the priest, the rabbi. How frustrating it must have been to our patients not to have these little niceties which perhaps are not part of the spiritual service but are so important in the total spiritual welfare. Sunday morning is no longer a difficult period at our hospital. Clothing rooms are always open. The ward doors are open. People go to church as they wish. Some are encouraged unless they express the desire not to go. What results from this? The previous number of 90 to 150 people at Mass in the Catholic chapel under supervision changed to 250 to 300 with no supervision and only a few have supervision and help because of physical condition or confusion. The same applies to our Protestant population but here another attitude has been expressed. The hospital has had a Catholic church on its grounds for 50 years, a beautiful, homey chapel which is quite inspiring not only to Catholics but to others who enter. Our Protestant patients had to worship in the recreation hall. Thursday night they danced there; Friday they watched or played basketball; Saturday they went to the movies there and then they began the next week by going to church there on Sunday. An understanding community that we serve has corrected

this. Seventy-five hundred people from the six counties which we serve donated \$260,000 and at this moment the construction of a Protestant church and Hebrew synagogue is under way and expected to be completed in November of 1958. Why did the community do this, and 7,500 people, not just one or a few large charitable donations? Our relatives and friends regard St. Lawrence not as a state hospital for insane but their hospital for their relatives and their friends. The community likes the open door system. They like going into the ward or dormitories or kitchens and visiting with their patients. They approve of the more normal way in which the patient lives. Visiting is no longer a day of lineups, telephone calls and frustration to those relatives who could only spend an hour or two in the hospital and wasted half of it in registering—locking doors—special visiting areas; visiting now is just another affair. People meet their relatives, go for a walk or a ride. They don't wait—they don't have to stay in one area—they don't have to eat at one table—they don't have to worry whether the patient has good manners or bad manners. They can take them anywhere on the grounds or in the building and help them, reteach them if necessary. The nurse now has time also to visit with the relatives, to see how the patient reacts. She does not have to jump up and down to perform the ritual of the key, that symbol of authority which can so disturb and even remove the dignity of an individual.

During 1956, some of the patients complained that the open door was fine but that the system could be changed back as rapidly as it had progressed and that they were not really trusted. They called attention to the grates on the windows which still remained as a symbol of confinement and authority. Removal of the grates started slowly, but as did the rest of the program, moved quickly. To date, over 2,000 grates have been removed from windows and only a very few remain which are being removed as time allows. The wards appear brighter, the windows are kept cleaner. Patients had poked holes through the window screens previously to push things outside or perhaps just to use as a peep hole. As the guards and grates were removed, the repaired screens were not damaged any more. The old scratches on the doors disappeared as the doors stayed open. A job of fixing screens, repairing damaged locks and doors disappeared and was replaced by something more worthwhile.

Our social service department, under the clinical director, soon found that more patients were being presented for release from the hospital. The "open door system" not only gave the patient freedom, it also removed from many the super-imposed symptoms of tension and irritability and no longer aggravated the delusions of persecutions. By allowing the patient to go outside and find other interests, the patient did not have to sit in a corner and find refuge in fantasy and hallucination. The patient's problems of his own illness became more apparent and, in many cases, the doctors could now speak to the patient and help solve the problem or find a suitable method of adjustment. Many of our patients had been in the hospital so long they had outlived relatives and friends or were no longer an integral part of the family constellation. We took advantage of our "family care" program. In this program the patient is placed in the community in a family home and becomes a part of the household. Our program increased from 75 to 200 patients in less than two years.

With other patients who still had family ties, renewed interest on the part of the family and patients and with solution of problems possible, the convalescent care program increased from an average of 170 patients to 300. This resulted in a drop of the resident population to the present 1,900 which is the lowest census this hospital has had since 1909 (highest about 2,264 during 1954).

Escapes are no problem. There never were many escapes at St. Lawrence, they averaged perhaps 10 a year. The number is less now and usually the patients go directly to their homes and we receive calls from the relatives as to where the patient is. Patients are encouraged to socialize and they mix freely. Pregnancies have not occurred at all to date. Likewise, suicide and accidents are no problem whatever.

Relatives are very appreciative of the new system. Patients, of course, like it and do everything they can to promote it and keep it successful. The community about the hospital has only good comments about it. Police, state troopers and sheriffs are very understanding when occasionally they return one of our wanderers.

The system takes a great deal of team work. It cannot be accomplished by order of the Director to open doors. It must be an all round program where the doctors, nurses, attendants, occupational therapists, recreational therapists, social workers, food service and every other department play their parts for the benefit of the patient and conversely for their own benefit since working conditions have so improved that personnel feel better and get along better. The authority of the key of confinement replaced by respect for the individual patient restores his dignity and self respect and at the same time restores the dignity and self respect of the personnel who can treat their fellow men as patients.

"Look at that patient run across the field! I wonder where he is going. He probably wants to get back to the ward to see the start of the program on T.V. at 7:30." The place—St. Lawrence State Hospital. The time—August 1958.

ELEVENTH WORLD HEALTH ASSEMBLY

At the meeting of the eleventh assembly in Minneapolis last May a budget for 1959 of \$14,287,600 was adopted. In addition, about \$6,000,000 of U.N. technical assistance funds will be available for its work and nearly \$9,000,000 have been contributed by member governments to the malaria eradication program as well as UNICEF allocation of material supplies. The 1959 program includes nearly 800 projects that cover practically every country and territory in the world. The program of smallpox eradication was adopted and the USSR is donating 25,000,000 doses and Cuba 2,000,000 doses of smallpox vaccine. For the research program the United States is made a contribution of \$300,000 in addition to its contribution to the regular budget and the malaria eradication program. Since 1948 WHO has grown in membership from 26 to 88 countries and the budget has increased from \$5,000,000 to more than \$14,000,000.

The New Brunswick Department of Health and Social Services¹

J. A. MELANSON,² M.B., Ch.B.(Edin.), D.Sc., D.P.H.
and R. D. DEFRIES,³ M.D., D.P.H.

NEW BRUNSWICK AS A PROVINCE

NEW BRUNSWICK is the largest of the three Maritime provinces having a total land area of 27,437 square miles. Approximately seventy-nine percent of New Brunswick is forested and about one-half of the forested area is Crown land. The forested area is chiefly in the center of the province, the population belt coinciding with the coastline and main rivers, particularly the Saint John River which flows from north to south along the western edge of New Brunswick. The borders of the province to the north, east and south are formed almost entirely by the sea. The main highway logically follows the population belt about the coastline and up the western side along the Saint John River, providing a circular route around the province with diagonal highways crossing the interior to join major population areas.

There are six urban centers with populations of approximately 10,000 or more. Three of these, Moncton (38,479), Saint John (52,491) and Lancaster (12,371), are located at the southern edge of the province. Fredericton (18,303), the capital, is up the Saint John River in a west central position. Edmundston (11,997) at the upper extremity of the Saint John River is in the northwest and Campbellton (9,967) is in the northern section of the province.

Approximately sixty-four percent of New Brunswick's 554,616 population is rural, and for the most part, engaged in the basic occupations of farming, fishing, lumbering and mining. The two major language groups are English (60%) and French (40%) each being dominant in different areas of the province, French, to the north and southeast and English, in the south and west.

The general death rate for 1956 was 8.4 per 1,000 population, (Canada 8.2); the birth rate 29.9, (Canada 28.0); the infant mortality rate was 42.2 per 1,000 live births, (Canada 32.0); and the maternal mortality rate was 0.4 per 1,000 live births, (Canada 0.6).

Provincial government estimates of public health expenditure for 1957-58 total \$8,400,085 and for social services, \$5,643,118. This compares with a total provincial budget of \$64,210,323.

¹One of a series presenting the development and organization of public health in each of the provinces and the Department of National Health and Welfare.

²Chief Medical Officer and Registrar General of Vital Statistics, New Brunswick.

³Consultant and Director-Emeritus, Connaught Medical Research Laboratories, University of Toronto.

HISTORICAL HIGHLIGHTS

- 1784—New Brunswick was made a province. Population of 16,000 scattered along the coast and various river valleys.
- 1796—The first Act relating to health “prevents bringing infectious distempers into the Port of Saint John”. The reference was to smallpox which was endemic in New England between 1788–1792.
- 1815—First appearance of leprosy in Canada was in New Brunswick among the early French settlers on the coast. The disease continued to spread locally in the counties of Gloucester and Northumberland. Legislation was passed in 1844 establishing a lazaretto on Sheldrake Island.
- 1824—First legislation was passed regarding mental illness, and in 1836 the first institution for the care of mental diseases was established in Saint John.
- 1832—The Saint John Water Company was given the right to supply the city.
- 1833—Due to the threat of Asiatic cholera which had been introduced into Canada along the St. Lawrence river in the previous year, an Act relating to quarantine was passed which provided “for the establishment of boards of health in several counties”.
- 1847—Typhus fever, introduced by Irish immigrants, caused more than 1,000 deaths. Partridge Island in Saint John harbour was used as a quarantine station and served for more than seventy years.
- 1854—New Brunswick was ravaged by Asiatic cholera introduced from Europe through the Port of Saint John.
- 1855—New Act established a board of health in Saint John with Dr. William Bayard as Chairman.
- 1865—Opening of Saint John General Hospital.
- 1887—Health Act was passed by the Legislature establishing a provincial board of health and the division of the province into districts each with a board. Dr. William Bayard, the first chairman, continued in office until 1903. He is regarded as the father of public health in New Brunswick. Registration of vital statistics was commenced.
- 1896—Diphtheria antitoxin was supplied free to physicians attending poor families, and for all cases in 1899.
- 1899—Dr. C. A. B. Addy (1899–1910) was named Provincial Bacteriologist.
- 1901—Series of outbreaks of smallpox; the disease continued endemic until 1920.
- 1910—Dr. William Warwick (1910–1911) succeeded Dr. Addy as Provincial Bacteriologist.
- 1911—Saint John Board of Health appointed Dr. George G. Melvin as Health Officer. Dr. Melvin was one of the pioneers in public health, continuing in Saint John until appointed Chief Medical Officer in 1918.
- 1913—The first provincial sanatorium was opened at The Glades. In 1915, Saint John opened its own tuberculosis hospital.

- 1917—Mr. John Hall, Sanitary Engineer of East Orange, New Jersey, U.S.A. carried out a health survey of the province as a preliminary step towards the establishment of a health department.
- 1918—Hon. William F. Roberts, M.D. was appointed Minister of Health, first in the British Empire, (1918–1925).
New Public Health Act established a central office with Dr. G. G. Melvin, D.P.H. as the first Chief Medical Officer, (1918–1932), and a public health laboratory under Dr. H. L. Abramson, Provincial Pathologist (1918–1933). The province was divided into health districts, each with a full time medical health officer.
All children were required to be vaccinated.
- 1919—Medical inspection of schools was begun.
- 1920—Venereal disease control clinics were established.
Registration of births, marriages and deaths was established under the Department of Health, conforming with the Dominion Statistics Act of 1918.
- 1921—Provincial public health nursing service was established.
- 1923—Compulsory pasteurization of milk was introduced in Saint John.
- 1925—Routine chest x-rays of students at Mount Allison University conducted by Dr. G. J. Wherret, Tuberculosis Diagnostician, (1925–1928).
Hon. H. I. Taylor, M.B., appointed Minister of Health, (1925–1927) and Minister of Health and Labour, (1927–1935).
- 1928—Diphtheria immunization of infants, pre-school and school children commenced on a large scale.
Dr. J. A. Melanson, D.P.H. was appointed Tuberculosis Diagnostician (1928–1933).
- 1932—Dr. William Warwick, D.P.H. appointed Chief Medical Officer, (1932–1940) succeeding Dr. G. G. Melvin, D.P.H.
- 1933—There was a reorganization within the Department of Health and the District Medical Health Officers who had obtained their Diploma in Public Health and had special training in tuberculosis work were allocated the duties of the Tuberculosis Diagnosticians.
- 1934—Dr. R. A. H. Mackeen was appointed Director of Laboratories, (1934–1957).
- 1935—Hon. William F. Roberts, M.D., re-elected Minister of Health and Labour, (1935–1938).
- 1938—Hon. P. H. Laporte, M.D., Minister of Health and Labour succeeded Hon. William F. Roberts, M.D., deceased.
- 1939—Hon. J. B. McNair, Q.C., Premier, was appointed Acting Minister of Health and Labour.
- 1940—Hon. J. Andre Doucet was appointed Minister of Health and Labour (1940–1944).
Dr. William Warwick, D.P.H. retired as Chief Medical Officer and was succeeded by Dr. C. W. MacMillan, D.P.H., (1940–1945).
- 1941—The administration of the Act respecting the Protection of Children and the Wartime Guardianship Act was transferred from the Department of the Attorney General to the Department of Health and Labour.

- 1944—Department of Health and Labour became Department of Health and Social Services.
Hon. F. A. McGrand, M.D., became Minister of Health and Social Services, (1944–1952).
- 1945—Province assumed complete patient maintenance costs in all tuberculosis sanatoria in province.
Dr. J. A. Melanson, D.P.H. was appointed Chief Medical Officer and Registrar General of Vital Statistics.
Hospitalization costs for acute poliomyelitis cases assumed by province.
- 1947—Enlarged program undertaken with the appointment of directors of hospital services, cancer control, sanitary engineering and tuberculosis control.
Moncton Tuberculosis Hospital opened.
- 1948—Health services extended through financial assistance of National Health Grants program.
Dental Health Division established.
- 1949—Division of Maternal and Child Health (including Nutrition Services) established.
- 1950—Division of Mental Health established. First mental health clinic opened in Saint John followed by clinics in Moncton and Fredericton.
- 1951—Treatment services under the Cancer Control Program were begun and treatment centers for x-ray therapy were established in four of the province's hospitals. In addition, radium therapy was also provided at the Saint John General Hospital.
Report of the Health Survey Committee completed, covering health, hospital and related facilities and services.
- 1952—Hon. J. F. McInerney, M.D., appointed Minister of Health and Social Services.
- 1953—Opening of Regional Laboratory, Moncton.
- 1954—New four-storey Provincial Laboratory in Saint John occupied.
Opening of new Provincial (mental) Hospital, at Campbellton.
Rehabilitation and public health education programs were provided.
- 1955—Opening of new Polio Clinic and Health Centre, Fredericton, including Regional Laboratory.
Appointment of a Chief Welfare Officer to administer the Social Services Branch of the Department.
- 1956—Legislation enabling Minister of Health and Social Services to enter into an agreement with the federal government on a hospital insurance plan.
- 1957—The establishment of an interim study committee for a hospital insurance plan for New Brunswick.
Dr. H. A. Bird appointed Director of Laboratories.
- 1958—Opening of Forest Hill Rehabilitation Centre.
Passage of Hospital Care Insurance Act and Public Hospitals Act.
Opening of new Regional Laboratory, Campbellton.
Establishment of Mental Health Clinic, Edmundston.
Under the Cancer Control Program, a Cobalt 60 teletherapy unit was installed at the Saint John General Hospital.

ORGANIZATION AND ADMINISTRATION OF PUBLIC HEALTH

Under the Public Health Act of 1918, New Brunswick was able to develop local health services by dividing the province into several health districts each supervised by a district medical health officer employed by the province. The health districts were further divided into sub-health districts — a sub-health district being synonymous with a county unit — each with a local sub-district board of health responsible for specified services. A local sub-district board of health consists of four members appointed by municipal, town or city council; one appointed by the Lieutenant-Governor in Council, and additional members from towns and cities in proportion to population. There is a permanent secretary for each board and this officer is responsible for the collection and registration of vital statistics in addition to clerical and administrative duties. The duties of boards of health relate primarily to the reporting of notifiable diseases, environmental sanitation, water and milk supplies, control of communicable disease and vital statistics. The boards appoint sanitary inspectors, sub-deputy registrars of vital statistics and other auxiliary personnel to assist in this work. The largest of the districts consists of four sub-districts with four boards of health, the district medical health officer serving as chairman for each board. The smallest health district contains only one sub-district, the remainder having two or more. At the present time there are six health districts in the province.

As early as 1921 a provincial public health nursing service was established, but this was discontinued in 1940 and the nurses employed locally, however, in 1942 the provincial public health nursing service was reorganized. At present, thirty-six district public health nurses are located in all the health districts, but in one sub-health district, the city and county of Saint John, the nurses are employed locally.

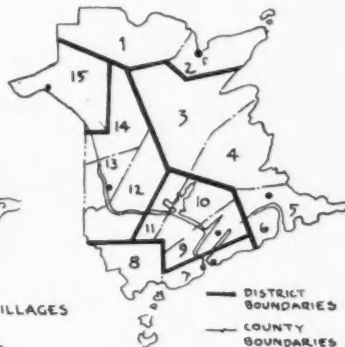
Notwithstanding the creation of health districts in New Brunswick by the Public Health Act of 1918, the greatest responsibility for public health is placed on the provincial authorities. Previous to 1947, the provincial department provided the basic services in public health, namely, recording of vital statistics; communicable disease control, including tuberculosis; sanitation; public health nursing; nutrition and limited laboratory services. In the field of treatment, the department administered sanatorium care for tuberculosis patients, maintained hospitals for mental patients and provided care for poliomyelitis patients.

Commencing in 1947, the department broadened its scope of services and activities. In that year directorships were established for hospital services, cancer control, sanitary engineering and tuberculosis control. In the years immediately following, directors were appointed for dental health, maternal and child health, mental health and health planning services. In 1954 rehabilitation and health education programs were added to the organization of the Health Branch.

The central organization, the Department of Health and Social Services, is divided into two sections, the Health Branch and the Social Services Branch, both under the Minister of Health and Social Services. The Chief Medical

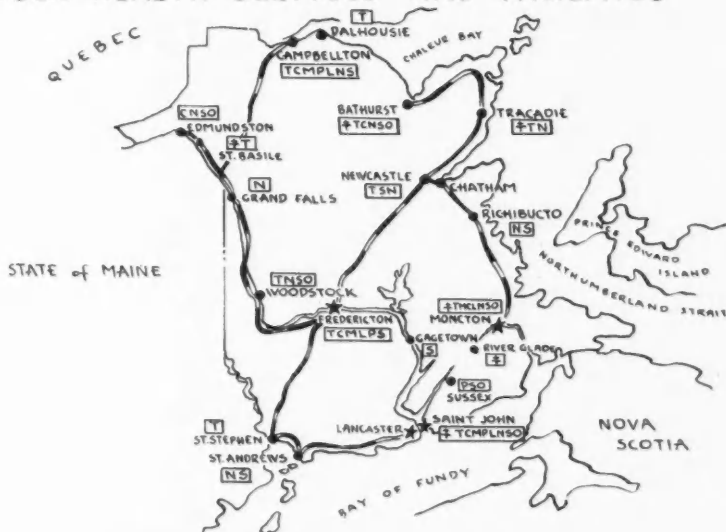
NEW BRUNSWICK

TOPOGRAPHY

FORESTED AREAS - HIGHWAYS
CITIES - TOWNS - VILLAGESCOUNTIES & HEALTH DISTRICTS
WITH POPULATIONS

HEALTH DISTRICTS

County	Population
1 RESTIGOUCHE	39120
2 GLOUCESTER	64119
3 NORTHUMBERLAND	47223
4 KENT	27492
5 WESTMORELAND	85414
6 ALBERT	10943
7 SAINT JOHN	81392
8 CHARLOTTE	24497
9 KINGS	24267
10 QUEENS	12838
11 SUNBURY	19020
12 YORK	47083
13 CARLETON	23073
14 VICTORIA	19020
15 MADAVASKA	36988

LOCATION - LOCAL AND PROVINCIAL
PUBLIC HEALTH SERVICES AND FACILITIES

Officer, who is also the Registrar General of Vital Statistics, is directly responsible to the Minister of Health and Social Services for the organization and administration of the department, as well as assuring the proper functioning of the sub-district boards of health. The Act facilitated this arrangement by the provision that the district medical health officer be chairman of the board or boards of health in his district.

At the present time the work of the Health Branch of the Department is divided into thirteen divisions as follows: Health and Vital Statistics, which also embraces Health Planning Services, Rehabilitation and Health Education; Accounting; District Medical Health Officers; Mental Health Services; Hospital Services; Cancer Control; Tuberculosis Control; Communicable Disease Control; Dental Health; Maternal and Child Health; Poliomyelitis; Sanitary Engineering; Nursing Service. In addition, there is also the Provincial Laboratories Service which includes laboratories at Saint John, Fredericton, Moncton and Campbellton.

HEALTH BRANCH

Health and Vital Statistics Division. Under this division are found the positions of Chief Medical Officer and Registrar General of Vital Statistics, Assistant Chief Medical Officer, Director of Health Planning Services, Assistant Registrar General, Rehabilitation Co-ordinator and Public Health Educator.

The *Vital Statistics* section is responsible for the collating, registering and recording of all births, stillbirths, marriages and deaths occurring in the province. In addition, birth, marriage and death certificates are issued from the central office.

The *Health Planning Services* section supervises the administration of the assistance program financed by the national health grants. It assists in the supervision of all health services in the department, and functions also in investigations and studies. The program of expansion of services in the department, commenced in 1947, was greatly forwarded by the national health grants. Under the General Public Health Grant, valuable assistance is given in establishing new services and extending the work of existing services. Under the various special grants, important additions are made to existing programs. The Hospital Construction Grant stimulates the construction of greatly needed hospital facilities.

The *Rehabilitation* program, under the direction of a provincial co-ordinator of rehabilitation, includes medical assessment, medical and surgical treatment, hospitalization, prostheses, vocational training and job placement services. More field staff members are being appointed to meet the growing demands for this service.

Health Education services are provided through a qualified health education consultant and are directed to all divisions of the department for the purpose of augmenting and improving the divisional programs. In addition, a generalized service is available on a departmental basis to cover the broad areas of publicity, public relations, consultation and information.

Accounting Division. All accounting for the department is centralized in this

division, which is directly responsible to the Chief Medical Officer. All official purchase orders for the department are issued by this division.

Mental Health Division. Two mental hospitals at Lancaster and Campbellton and four full-time mental health clinics, located at Fredericton, Saint John, Moncton and Edmundston are part of a comprehensive program conducted by the department. Patients are seen at the clinics by referral through practising physicians, public health nurses and voluntary agencies. Additional activities in health education and research are carried on in co-operation with the provincial division of the Canadian Mental Health Association.

Cancer Control Division. The program provides free diagnostic service to patients through their physicians at any of the six diagnostic clinics established in the province. There is free radiation therapy under specified circumstances. In addition, a direct and free service is provided to all doctors for the examination of biopsy specimens.

Hospital Services Division. This division assists and supervises in the development of plans for hospitals and ensures that plans for hospital construction conform with established standards. In addition, this division provides a general advisory and inspection service for all hospitals in the province.

Communicable Disease Control Division. This division receives and assembles weekly reports of notifiable diseases and assists district medical health officers and boards of health with epidemiological problems. It is responsible for the overall immunization program in the province to which poliomyelitis vaccination was added in 1955. The department supplies the essential public health biological products without charge and maintains serum depots to facilitate the distribution of biologics. The division co-ordinates the services of these depots, the work of the laboratories, and other divisions as they apply to preventive programs for the control of communicable diseases.

Tuberculosis Control Division. The primary responsibility of this division is case-finding. There are eleven diagnostic clinics in appropriate locations in the province. These clinics are conducted by the district medical health officers in the respective areas, by the tuberculosis control division with personnel from sanatoria and by the regional tuberculosis consultant. Contacts of known cases and former patients comprise the largest group attending clinics, the remainder being referrals from physicians.

In addition to the clinics, the division has established admission chest x-ray units in fourteen hospitals. A third phase of the case-finding program is mass x-ray surveys carried out in co-operation with the New Brunswick Tuberculosis Association. The case-finding program is co-ordinated at the tuberculosis central registry and film development center located in Saint John under the supervision of the director of the division. As a step to improving the case-finding program in the northern section of the province, a tuberculosis consultant was recently appointed for that area.

In the treatment and rehabilitation of tuberculosis cases, five sanatoria are in operation, two being provincially owned. These sanatoria are all under the supervision of the director of tuberculosis control as far as treatment is concerned. Treatment is free to all residents in the province.

The sanatoria include two provincial institutions, the Jordan Memorial

Sanatorium at The Glades, opened in 1913, and Moncton Tuberculosis Hospital opened in 1947. In addition there are the Saint John Tuberculosis Hospital, opened in 1915, Notre Dame de Lourdes Sanatorium at Vallee Lourdes opened in 1932 and St. Joseph's Sanatorium at St. Basile, opened in 1946.

Dental Health Division. The primary function is education and consultation and the greatest efforts are directed to schools. The division has promoted the establishment of school dental clinics in Saint John and Moncton and community dental clinics for needy children in six other centers. Dental hygienists work in the field under the dental health director.

Maternal and Child Health Division. This division conducts its program primarily on a consultant and research basis. Its specific functions deal with the administration of the Crippled Children's Grant and the Child and Maternal Health Grant. It promotes public and professional education, supplies information to hospitals and medical practitioners, conducts statistical studies, furthers the provision of modern equipment and procedures for new-born services in hospitals, maintains the crippled children's registry and co-operates with voluntary agencies concerned with handicapped children.

Under this division is the nutrition section with a senior nutritionist and three junior nutritionists who carry out a broad nutrition program for schools, hospitals, jails and other institutions, or interested public groups.

Poliomyelitis Division. The physiotherapists employed under this division are responsible for the administering of treatment to poliomyelitis patients and other handicapped persons at the Polio Clinic and Health Centre and at the Forest Hill Rehabilitation Centre.

Sanitary Engineering Division. This division provides consultation to communities on sewage disposal, stream sanitation, waterworks systems, purification of water supplies, food sanitation, and pasteurization of milk. This division also supervises the training of sanitary inspectors in the districts and assists the inspectors with their local problems when necessary. The division sponsors a mobile laboratory which operates in the rural areas during the summer for testing of water samples.

Public Health Nursing Division. One or more district public health nurses are located in each of the sub-health districts under the direct supervision of the director. The nurses work in collaboration with the district medical health officer and at the same time, co-operate in the program and services of the provincial department as they affect their own area.

Laboratory Division. With the opening of the new building to accommodate the central provincial laboratory at the Saint John General Hospital, and with regional laboratories located at Moncton, Fredericton and Campbellton, New Brunswick is exceptionally well provided with laboratory diagnostic services. The laboratory division was one of the first divisions to be established (1918) and distinguished laboratory directors have developed the program. Dr. H. L. Abramson, the first pathologist, laid the foundation of the program and Dr. R. A. H. Mackeen who succeeded him in 1934, planned and developed the central and branch laboratories. The laboratories provide bacteriological, biochemical, serological and haematological services as well as tissue pathology and rhesus factor investigations.

MEDICAL CARE SERVICES IN NEW BRUNSWICK

There are thirty-four hospitals, exclusive of sanatoria and mental hospitals with a rated capacity of 2,300 active treatment beds. Proposed new construction will increase the number of beds to 3,221. The number of physicians registered in the province as of 1958 was four hundred and thirty-nine. There are one hundred and twenty-three dentists registered as of 1958.

Voluntary Prepaid Hospital Insurance. In 1937 a group hospitalization plan was established which operated chiefly for subscribers in the Moncton area. For some years it operated concurrently with the Maritime Blue Cross Plan and upon application, in 1949, the subscribers were transferred to the Maritime Blue Cross Plan. Voluntary prepaid hospital insurance was introduced in New Brunswick by the Maritime Hospital Service Association in 1943 and was supplemented in 1949 by the introduction of the Blue Shield Medical Care Plan. The latter provides insured services in the medical and surgical fields and is offered chiefly to groups. It covers approximately 17% of the population. It is estimated that an additional 15% of the population is insured for medical and surgical care with commercial companies. There are no medical care plans in New Brunswick sponsored by the medical society or physicians' groups.

Federal-Provincial Hospital Insurance Plan. The Hospital Care Insurance Act under which the plan will operate has been enacted by the Legislature. Hospital services will be available to all residents in the province and the Act will be administered by a hospital services commission. It is anticipated that the plan will be in operation in 1959.

SOCIAL SERVICES BRANCH

In 1944, the Department of Health and Labour became the Department of Health and Social Services. Previously, welfare services had been administered under various government departments, including the Department of Education, Federal and Municipal Relations and the Department of Health. The establishment of the Social Services Branch placed the Old Age Pension Board under the Minister of Health and Social Services.

The Social Services Branch was further reorganized in 1955 with the appointment of a chief welfare officer. This position, comparable to that of the chief medical officer in the Health Branch, was established due to the rapidly increasing demands for welfare services. The duties of the director of the pension board were combined with those of the chief welfare officer. Concurrent with this change was the appointment of a director of welfare under the chief welfare officer.

The Social Services Branch includes trained social workers under the supervision of the director of welfare. It is his duty to work closely with the Children's Aid Societies in their work with adoptions, unmarried parents, neglected children and general child care services for all children sixteen years of age and under. There is a field staff of 21 persons engaged as pension investigators.

Old Age Pensions. Old Age Pensions were first paid to persons seventy years and over in New Brunswick under an agreement with the federal government,

which assumed 75 percent of the cost. The pensions were paid under an income eligibility test and in 1935 were limited to an annual amount of \$240. In 1943 they were increased to \$300, in 1947 to \$360 and finally to \$480 in 1949. With the passing of the federal Old Age Security Act, effective from January 1, 1952, all persons seventy years of age and over became the full charge of the federal government. On the same date the Old Age Assistance Act and Blind Persons Act became effective.

Old Age Assistance Act. This Act provided for the payment of assistance to persons between the ages of sixty-five and seventy years, under an agreement between the federal and provincial governments. Assistance is paid on an eligibility test, with an annual income ceiling, including assistance, set at \$960 for single persons and \$1,620 for married persons. The maximum assistance is \$55 per month, and the cost of pensions is shared equally by the federal and provincial governments.

Pensions for the Blind. Allowances are paid to blind persons between the ages of eighteen and seventy years, whose annual income, including the allowance, does not exceed \$1,200 in the case of a single person or \$1,980 if married. The maximum monthly payment is \$55 and 75 percent of the amount is reimbursed to the province by the federal government.

Related to the administration of the Blind Persons Act is the provision for operative treatment for recipients recommended for treatment by a certified oculist.

Mothers Allowances. The Mothers Allowances Act, provincial in scope and fully financed from provincial funds, was introduced in 1943. This act is designed to assist needy mothers with dependent children, whose husbands are dead, permanently and totally disabled or in a tuberculosis sanatorium or mental hospital. The allowance is also paid to mothers who have been deserted for a period of two years, with the husband residing outside the province. In 1958 the provincial Legislature approved of payment of the allowance in cases where the husband has been recommended for rehabilitation training by the provincial rehabilitation co-ordinator.

The allowance for a mother and one child is \$35 per month with an additional \$10 per month per child, to a maximum of \$80 per month. A rental allowance of \$10 per month may be paid, provided the total allowance does not exceed \$80 per month. In addition to the allowance, a mother may have an earned income of \$80 per month — income over this amount is deducted from the allowance. The maximum eligible age for children is seventeen years, however, if the child is attending school at the time of its seventeenth birthday, the allowance may be paid until the end of the school year.

Disabled Persons Allowances. On January 1, 1955, the Disabled Persons Allowances Act provided for the payment of a monthly maximum allowance of \$55 to all persons eighteen to seventy years of age ruled to be permanently and totally disabled. The same income ceilings as under the Old Age Assistance Act apply, and 50 percent is paid by the federal government.

The cost and responsibility for the administration of the Old Age Assistance Act, Mothers Allowances Act, the Blind Persons Act and the Disabled Persons Allowances Act rests with the province.

Dental Disease and its Relation to Public Health in Alberta¹

S. P. C. CASEY,² M.B., D.P.H. AND C. R. CASTALDI,³ D.D.S., M.S.D.

RECENT surveys by the World Health Organization have indicated that dental and oral disease has now surpassed malaria and the common cold as the most prevalent affliction of man. The rise of dental and oral disease has come about not only because of the success of public health measures in combatting communicable diseases, but also because dental and oral disease is on the increase. The purpose of this paper is to present concrete facts which can serve as a basis for attacking dental disease through prevention and education.

Several weeks ago, a visit was made to the well-baby clinics in Wetaskiwin and Ponoka where pre-school children were being given their periodic health examinations. The populations of Wetaskiwin and Ponoka are approximately the same and the socio-economic levels are comparable. The only apparent difference between these two communities is the fluorine content of the public water supplies. In Wetaskiwin the level varies between 1 and 2 ppm while in Ponoka it is, on the average, 0.5 - 0.7 ppm.

Most of the children were free of systemic disease, had no severe congenital deformities, were not suffering from malnourishment and, accordingly, the children of the two towns might be considered two fairly similar groups of well children. Dental examinations carried out with no more facilities than a tongue blade and the naked eye revealed startling differences. Of 27 children examined in Wetaskiwin, 24 lived within the city limits. The total number of decayed teeth was 39, the number of missing or extracted teeth was 11, and the number of filled teeth was 13. Of 43 children examined in Ponoka 26 lived within the town limits. The decayed, missing, filled index (D.M.F.) of these children was 211, 38 and 11. There were also sharp differences between the two groups of children as far as the number of caries-free children was concerned (Table 1).

TABLE 1—INCIDENCE OF CARIES

	Number of Children	Number Caries-free
Wetaskiwin (Town proper)	24	13
Ponoka (Town proper)	27	1
Wetaskiwin (Farm children)	3	0
Ponoka (Farm Children)	16	8

The interesting aspect of Table 1 is that all of the farm children from the Ponoka area were drinking water from deep wells of which the fluorine content

¹Presented at the annual meeting of the Alberta Public Health Association, September 1957.

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³Professor of Pedodontics, University of Alberta, Edmonton, Alberta.

has repeatedly shown high values (1.7 ppm) while the 3 farm children from Wetaskiwin were drinking water from shallow wells the fluorine content of which was below 1 ppm.

In addition to the dental examination the following questions were asked of the parents:

Has your child ever had a previous dental examination?

	YES	NO
Wetaskiwin	13	14
Ponoka	21	22

What do you think is the best age for your child's first dental examination?

	AGE — 2	3	4	5	6	DID NOT KNOW
Wetaskiwin	4	—	4	1	4	14
Ponoka	4	—	13	4	5	

Do you think that the "baby teeth" should be filled if cavities develop?

(This question was asked only in cases where child had never before visited a dentist).

	NO	YES	DID NOT KNOW
Wetaskiwin	6	4*	4
Ponoka	5†	6*	11

†Child already had acute alveolar abscess requiring antibiotic therapy.

*Financial problem for parents.

Do you think that a filling in a baby tooth should cost (a) the same, (b) more, (c) less, than a filling in a permanent tooth?

	SAME	MORE	LESS	DID NOT KNOW
Wetaskiwin	8	1	8	10
Ponoka	8	1	15	19

In addition to these questions a review was made of the medical officer of health's report of 418 defects in school children examined during the first quarter, 1957. Of these defects, 287 were teeth, 97 throat, 56 cervical glands, 48 ears, 27 orthopaedic and 105 were others. The medical officer of health reported: "Dental decay heads the list of defects. This is the usual finding following the physical examination of school children, and judging from other health unit reports, the same obtains throughout the province".

The dental survey of the two groups of pre-school children is very small and consequently not conclusive. The survey does help to point out pertinent issues in the problem of dental disease in the province of Alberta. These are:

1. Where public water supplies contain more than 1 ppm fluorine there is a considerable reduction in dental caries in pre-school children.
2. Despite this reduction, a small amount of dental caries does exist even when the fluorine content of the water is between 1 and 2 ppm fluorine. To prevent loss of teeth, adequate dental services are necessary as well as adequate fluoride content.
3. The education of the public regarding modern dental care is very important.

It has been estimated that of a total of one billion dollars spent annually by Canadians for health care about seventy million are spent for dental services. Despite this tremendous outlay about 35 per cent only of the population receives dental care. It is obvious that dental and oral disease should be recognized as the number one health problem in the province of Alberta.

The day when dental and oral disease can be controlled is still distant, however, we have very effective tools to make a good start. All that is necessary is a concentrated effort toward putting into effect the preventive measures now available. These measures are: fluoridation of public water supplies, education, treatment of pre-school-age children, and research.

FLUORIDATION

The facts are irrefutable concerning the positive effects of fluoridation of public water supplies in reducing tooth decay. In 1954, the province of Alberta conducted through its Research Council an unbiased technical survey of the effects of fluoridating public water supplies. The concluding statement reads: "Now therefore be it resolved that this committee gives its unqualified endorsement of the principle of the addition of soluble fluorides to fluoride deficient public water supplies in Alberta to bring the fluoride concentration up to 1 ppm fluorine, subject to the detailed regulations of the provincial board of health governing the fluoridation of water supplies" (1).

Further conclusive evidence regarding the effects of fluoridation have recently been published by Dr. Louis Dublin (2), entitled "Water Fluoridation: Facts not Myths". As chief statistician for the Metropolitan Life Insurance Company until his retirement in 1952, Dr. Dublin had at his disposal the statistics of life and death, health and disease, for millions of people in North America. Following his retirement in 1952, Dr. Dublin and associates spent a year collecting, filing and computing figures on fluoridation.

Despite the report of the Alberta Research Council and the statistical survey by Dublin, the issue of fluoridation is being decided in Alberta on the basis of plebiscites.

The opponents of fluoridation are using every conceivable underhanded trick to thwart the efforts of the public health workers. Their assertions include absurd statements such as that fluoridation increases the chance of conception in humans, and that it will ruin the mink-raising industry. The fact that public referenda should be held to decide on the merits of water fluoridation puts scientific evidence and scientific facts in a ridiculous light. Furthermore, a voting arrangement which allows one NO vote to be equal to two YES votes on a health matter of proven safety makes a sham of the democratic principles under which we live.

EDUCATION

The logical question associated with the broad area of education is: what positive effects can be accomplished? Here, we have a well-conducted Canadian study for our guide. A dental health program was instituted in the Elgin-St. Thomas area in Ontario in 1951. Personnel consisted of a dental health officer, a clerk and a secretary. A program of dental examinations with

referral cards and presentation of oral and nutritional health education by means of visual aids was set up in primary schools. The results of this project as reported in 1957 are as follows.

A substantial increase in the number of children who had all dental caries treatment requirements was accomplished by the dental practitioners in Elgin County in response to the demand created by the dental health education program. Since the dentists were fully employed at the start of the program it is presumed that the increase in dental service for children was made possible by a deferral of treatment for adults in many instances, but perhaps to a large extent it was due to early dental care when incipient lesions could be readily treated, thus avoiding time-consuming operations occasioned by neglect. In this manner, more patients per man-hour could be accommodated.

A significant decrease in the caries attack rates over the four year period of the educational program suggests the practicability of reducing the incidence of dental disease through health education. There is also evidence that the benefits of water fluoridation in a community may be enhanced through the teaching and individual acceptance of good nutritional and oral hygiene habits.

At the beginning of the program, the dental treatment backlog for the children receiving fluoridated water was not a great deal lower than in the non-fluoridated regions despite a much lower attack rate in the fluoride region. It seems clear that the benefits of water fluoridation may be lost to a considerable extent if early treatment is neglected for those carious lesions which develop even in the presence of water fluoridation.

TREATMENT OF PRE-SCHOOL-AGE CHILDREN

Modern dental care begins with the education of the expectant mother regarding the development of primary teeth as the child proceeds from the embryonic to the foetal stage of its life. The next most important stage begins at the second-year level when every child should have a dental examination and any care necessary instituted. The positive results of early and continuous care have never been more clearly indicated than in a study of two areas which were shown to have identical dental caries rates.

Since 1910 a school dental program has been conducted in Oslo, Norway in which children are provided annually with dental care (4). A comparison was made of 296 thirteen year old children with a group of 370 thirteen year old children in Richmond, Indiana where no such treatment program had been in effect. The decayed, missing, filled, index of the two cities was the same, however, in Richmond, Indiana each child had an average of 7.5 teeth decayed while in Oslo the average was 0.5. In Oslo, the average child had 8.5 teeth filled as compared to 1.5 in Richmond. The most significant finding concerned the number of permanent teeth extracted. In Oslo, for every 100 children 6 teeth were lost; in Richmond, for every 100 children, 100 teeth were lost.

The Canadian Dental Association has taken cognizance of this and similar studies and has recently issued a policy statement on prepaid dental health plans stating that any plan should include treatment for the young age groups only, and specifically for the pre-school-age child. The reasons for this are obvious; we have not enough dentists, consequently, where dental treatment time is at a premium it should be used where it will do the greatest good, namely, in the treatment of children. As Robert Kesel of the University of Illinois has said: "If more effort is not put into remedial dental service for

children we will continue to reap in adults the results of disorganized child care" (4).

RESEARCH

Many factors in dental caries and periodontal disease are still not known. A considerable amount of dental research is needed to solve the unanswered problems. In the area of dental research there is reason for optimism in that both federal and provincial authorities have shown very definite signs of awakened interest. Perhaps our greatest problem here is in the shortage of well-trained dental scientists for the investigational work. Such work need not be confined to dentistry. According to John Knutson of the United States Public Health Service:

"We are in dire need of knowledge of the forces which motivate people to action in relation to health matters or which foster doubt, indifference, procrastination and even violent opposition based on bizarre combinations of information and misinformation. The striking similarity in frustrating experiences in water chlorination beginning with this century and today's program of water fluoridation should point out the long overdue need for basic sociological studies in this area."

SUMMARY

A four-point plan for better dental health has been outlined. The most important factor in the whole plan is—where and how does such a plan get started? Obviously, it starts at the provincial level where a dental division in the public health department is sorely needed. Alberta is the only province in Canada which does not have a director of dental public health. Until a dental division in the public health department is established under a qualified director with the necessary authority to institute a modern dental health program, dental health in the province of Alberta will continue to decline.

Some idea of the cost of the program can be gained from recently published data describing the dental health program in Greater Toronto which has a population comparable to the total population of Alberta (5). The dental budget for Toronto in 1956 was approximately \$225,000 (10% of the total public health budget). There were 82 persons on the staff (15% of total public health staff) and of these 59 were part-time staff and the remainder were full-time. It would be difficult to determine whether a staff of this number operating with a budget of this size would suffice for a province-wide program involving the same number of people. The fact remains that in 1956 Albertans paid approximately \$1,000,000 for the treatment of dental disease. Much of this disease could have been prevented by proven public health measures but these measures have yet to be put into effect in the province of Alberta.

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The Role of the Voluntary Health Agency¹

CHRISTIAN SMITH²

IN the growing complexity of our society, the voluntary organization has a place of tremendous significance. In recent years the number has increased phenomenally, until the question has been asked whether we are not, in fact, becoming over-organized. At the same time there is some questioning about conflicting or overlapping programs, efficiency and economy, and such matters as financial appeals.

Over the years certain philosophical principles have emerged and have found general acceptance, and these relate to the role of the voluntary agency and its relationships to public agencies.

In the days of our grandparents much of what is now done by official and private agencies was left to persons and families. When there was hardship or sickness in the home of a neighbour, our grandparents and others voluntarily did what they could to alleviate immediate distress, such as contributing food and fuel, or perhaps beef broth or nursing care to someone who ailed. This private charity may have been inadequate and missed many needy persons, but it had great value in fostering among people generally a sense of responsibility for the welfare of others.

Religious organizations provided the first organized efforts to bring succour or care to the needy. The voluntary welfare or health organization we know today is a relatively recent development. Although many of them in the past have been concerned with services to special groups in the population, selection being made on a religious or social basis, more and more of them in recent years have been interested in people irrespective of such differences.

One of the principles now commonly accepted grew out of the activity of these voluntary societies in demonstrating needs and measures to meet them, in developing and proving new ideas and techniques. As these organizations grew in activity they soon found that some needed services were beyond their capacity, and the state—represented by local, provincial, or national government—was persuaded to accept responsibility. Out of this came the idea that the voluntary agency is most useful in the role of pioneer, innovator, demonstrator, trail-blazer.

The idea also developed, that as a voluntary agency concluded an activity or relinquished it to government it had the choice of turning to other unmet needs or discontinuing.

It was observed, however, that even when the state took responsibility for meeting a social need on behalf of all its citizens, important gaps were often left. Due to the very nature of having to deal with people in the mass, there were and still often are, situations which are not met by state programs.

¹Presented at the forty-fifth annual meeting, Canadian Public Health Association, Toronto, May 27-29, 1957.

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Today, people living in Saskatchewan municipalities and insured for hospital and ordinary medical care, sometimes find themselves faced with staggering bills resulting from specialists' services or a journey to a distant clinic. Thus, even where the state has taken responsibility for certain services to people in the mass, there are still numerous opportunities for the voluntary associations to exercise their old function of assisting individuals.

Another recognized function of the voluntary organization is the development of public understanding of needs, programs, ideas, and policies. All this is done best by the participation of many people in the variety of causes represented by our voluntary organizations.

If we examine the many different ways in which the ordinary citizen is involved in the advancement of health in our country we must start at grass roots. There is a large number of community groups which have an interest in public health although that is not their primary purpose.

Voluntary Agencies in Saskatchewan

In Saskatchewan there are some hundreds of thousands of citizens who participate in voluntary health activities. For instance, there is the Provincial Council of Women, a federation of many kinds of organizations, with an estimated membership of 150,000. It is recalled that one of its constituent groups, the Saskatoon Council of Women, campaigned successfully a few years ago for milk service by the half-pint bottle instead of the glass in public eating places. The Provincial Council of Women, a decade ago, threw its influence behind a proposed provincial pasteurization statute and helped to make it law.

The Saskatoon Junior Chamber of Commerce courageously pioneered a venereal-disease-education program in the first year of World War II and later involved some 55 brother organizations in similar endeavours.

The Home and School Associations of Saskatchewan were the axis for a unique procedure of the Department of Education when it rewrote the elementary school health curriculum several years ago. The department asked the parents and teachers to discuss health education in the school and come forward with suggestions. The Department of Public Health provided consultation and educational services to these associations and had the satisfaction of witnessing the adoption of its suggestion that home and school should have common health objectives and standards.

A unique federation is that of the Homemakers Clubs in Saskatchewan. There are 450 of these largely rural groups (known as women's institutes in other provinces). They have a provincial health convener, 16 district health conveners, and a health convener for every one of the clubs. The provincial convener suggests main emphases for the year and the others may accept these or devise their own subjects. Each convener is permitted to plan and present a health program for one of the 12 meetings in the year.

It has been interesting to note that a substantial support for cancer, Red Cross and mental health work comes from the small yearly donations of these clubs. The subjects of the once-a-year health programs may be gerontology, home safety, mental health, or some like topic.

Another important group is the 1,000 women's locals of the Saskatchewan Farmers Union, who this year are pressing for the extension of public health services in the remaining unorganized areas of the province. They have a provincial president and a health convener who personally interpret the work of public health units and their value to the rural people. The S.F.U. locals are currently also raising money for the psychiatric department of a Regina hospital.

The Independent Order of the Daughters of the Empire has for many years financed the "preventorium" at Fort Qu'Appelle Sanatorium, where babies of tuberculous patients are taken immediately after birth and isolated from possible infection. The biggest value of this was to establish beyond question that tuberculosis is not inherited.

These, then, are some of the voluntary organizations which are making democracy a living, vital experience in Saskatchewan, and one is sure that their counterparts are to be found in every province. They are, as mentioned, groups which do not have advancement of health as their primary or only concern.

The interest of the voluntary groups, and of the public generally, in matters of health has a long history in Saskatchewan—at least, long for a young province. From the days of earliest settlement the people have been concerned with problems of medical and hospital care, preventive services, and related subjects. They discovered early that what they could not very well do as individuals or families they could do co-operatively with their neighbours and fellow townsmen; and what could not be done by one municipality might be accomplished by a number of municipalities acting together.

This is one reason why no eyebrows are raised in Saskatchewan at mention that the budget of the Department of Public Health is \$27,671,060.00 for this fiscal year constituting 29% of the operating expenses of the government. This mature public attitude toward public health services was also one of the reasons why the Canadian Mental Health Association six years ago encouraged the organization of its first provincial division in Saskatchewan.

The voluntary agencies which have health advancement as their sole purpose have multiplied a number of times since World War II. As in other parts of Canada, each has been established by volunteers to cope with some specific health problem or small group of problems. Nearly all enjoy considerable public participation and adequate financial support, this depending largely on their own skill or lack of skill in public relations.

The public has a substantial confidence in these organizations, which are generally under responsible management of public-spirited citizens, some of whom may have a personal interest in the situations which the organizations are battling. The programs vary, from money raising for research and some educational activity to providing summer camps for children suffering from a chronic disease such as diabetes or a defect such as mental retardation. All of them depend upon public subscription for their continued existence and few of them suffer hardships, although nearly all could visualize expanded usefulness if they had more money.

The Department of Public Health looks upon these voluntary agencies as

an indispensable ingredient of democracy and performing vitally important services in exploring and demonstrating unmet needs, educating and organizing the public for essential services, and putting to work thousands of dollars to supplement what the contributors have already paid in taxes.

A notable example of this was the Saskatchewan division of the Canadian Mental Health Association, which in its first three years enjoyed the help of both the federal and provincial health departments. Today, the division has more than 30,000 members in Saskatchewan and no longer needs government grants. There is something to be said for and against government support of such a voluntary association. Certainly, it takes money which may not be immediately available from the rank and file of the people to start an organization and get it functioning efficiently in a short time. Government help may suggest to some that the recipient agency is under obligation and therefore not as free as it should be. If this is so, the C.M.H.A. in Saskatchewan seems to be unaware of any impediment. It has followed a vigorously independent policy, pressing on public and government alike its conception of what needs to be done on behalf of the mentally ill.

The voluntary health agencies are of two kinds: those which originated in the province because men and women were sufficiently concerned, and those which have developed through prompting and organization by national parent organizations. The Saskatchewan Council for Crippled Children and Adults is in the first category. Like others of this type, it has affiliated with a national body. The Saskatchewan divisions of the Canadian Cancer Society, the Canadian Diabetic Association, the Canadian Mental Health Association, and the Rheumatism and Arthritis Society are good examples of the second group.

Most of the Saskatchewan branches and divisions of national organizations appear to be virtually autonomous, supporting national objectives and national financial needs while developing and maintaining policies and programs which appear to them best suited to their environment. They receive certain services from national offices, which effect economies and provide materials difficult to produce in smaller cities.

The various health agencies in Saskatchewan have not been greatly troubled by the complaints heard elsewhere about multiplicity of appeals, special days and weeks, or conflict of interests. The public does not appear to consider that there is too much emphasis on any particular health problem. The Department of Public Health enjoys harmonious relationships with virtually all the organizations, and there is considerable cross-consultation, exchange of facilities, and cross-referrals.

One organization which does not appear to have its equal anywhere in Canada is the Saskatchewan Anti-Tuberculosis League. For many years the League has had complete charge of the tuberculosis program, operating with government per diem grants and receiving the remainder of its funds from the urban and rural municipalities, which are assessed their shares on a land value basis each year. This organization was launched in 1912. Even then, the public health authority of the province welcomed voluntary effort in the health field, as the late Dr. Maurice Seymour, the first commissioner of health for Saskatchewan, was instrumental in the organization of the League. The

board of directors of the League has on its representation of government, urban and rural governments and various other interests. In addition to the public funds for the diagnostic and treatment services of the League, there is a preventive program which is financed wholly by voluntary subscriptions totalling about \$150,000 a year.

National Voluntary Health Agencies

On the national scene are organizations familiar to all of us, among the earliest being the St. John Ambulance Association, the Victorian Order of Nurses, the Canadian Tuberculosis Association, the Canadian Red Cross Society, the Health League of Canada, and the Canadian Mental Health Association, which until 1950 was known as the National Committee for Mental Hygiene (Canada.)

The Health League of Canada had its origin as a committee to combat venereal disease later becoming the Canadian Social Hygiene Council. The organization became the Health League of Canada in 1935. The original committee resulted from the concern of its founder and the present general director of the League, Dr. Gordon Bates, with the widespread incidence of venereal disease. Before he had an organization, Dr. Bates and friends organized nationwide pressure upon the national government to do something about the problem. From this resulted the first health grants to the provinces for the purpose of providing free diagnostic and treatment clinics for indigents and transients, but, even more important, the establishment of a national health department. The federal government recognized the need for public education and assigned this responsibility to a committee which Dr. Bates was to form for the purpose, providing for an annual grant to finance this work. When the federal authorities, in 1925 considered abolition of the grants, the committee under leadership of Dr. Bates circularized a large number of Canadian organizations for protection, an effective procedure. Both the grants to the provinces and the grant to the voluntary group were continued until they were abolished by a new administration early in the 1930's. The grants to the provinces were re-established later.

The Health League thus filled its role in the accepted sense in drawing attention to an important need and being, as it were, a watchdog for the public to see that the new program was maintained, and when this could not be done, to have it reinstituted.

In the 1930s the League's program was broadened to include other problems. Its Toronto Toxoid Week, in which the League helped the city's health department to achieve a remarkable record of freedom from diphtheria, later grew into National Immunization Week.

Political leaders often will not risk public displeasure, even from small groups of vested interests, to introduce some needed public health measure, and it was with the blessing and support of an Ontario government that the League successfully undertook the education of the people in that province to endorse a provincial milk pasteurization law. The League was also interested in nutrition education and in industrial health. The Health League has also given an excellent demonstration of citizen involvement, from the successful

men that serve on its board to the men and women who work on its committees.

The National Committee for Mental Hygiene was founded by Dr. Clarence M. Hincks in 1918. For many years Dr. Hincks and his associates, backed by a board of prominent and generous Canadians, provided a valued consultation service to provincial health authorities, initiated special studies with funds from wealthy foundations, and found help for promising professional men seeking further training. The Committee became multi-disciplinary with psychologists, sociologists, and others joining in its activities. In 1950, persuaded that the mental health movement in Canada should set its sights higher and that obvious objectives could be achieved only by the involvement of the public, the Committee became the Canadian Mental Health Association, "a partnership of the people of Canada with their doctors". The change was made at a time when the public itself was evidently ready for it, for the C.M.H.A. has had a phenomenal growth and has been able to institute programs of far-reaching consequences for the public welfare.

There are, of course, other national health organizations which have likewise found wide acceptance and support, and are making tremendous contributions to the public good. Two pioneer organizations have been discussed at some length because they are fairly representative. Some, undeniably, are more effective than others, some are not as well received as others by either the public or the official health departments. Sometimes this is a matter of personalities, but in other instances it may be because some fundamental principles have been overlooked.

It has been observed in one or two organizations that citizen groups are not used as democratically as they might be. Instead of being informed and given an opportunity to develop programs, policies are decided elsewhere. Under such conditions a citizen group becomes little more than a rubber stamp.

Sometimes, too, there is a lack of elasticity, an ability and willingness to change with the times, to let go of finished tasks, or to go on to new challenges. This is a denial of the accepted role of the voluntary agency as a trail blazer, demonstrator, and innovator. One organization went so far as to complain against the tendency for government to take over functions which it had considered its private preserve!

There are so many new and unmet challenges in the field of public health that one wonders why voluntary effort is still concerned with activities which have become important programs of the official agencies. Among the unmet problems may be cited the dental ill-health situation in Canada, including the acute shortage of training facilities and educational funds for dentists. There is need of national leadership for the attack on accidents. Canada has no body comparable to the voluntary National Safety Council in the United States, with which Canadian safety groups now find it convenient to affiliate. How about the vast problem of chronic disease and the neighbouring needs of an aging population? Voluntary effort with respect to these national problems has been either unborn or fragmentary, and in the meantime we have voluntary effort directed toward matters which are no longer as important as they once were, or have been taken well in hand by official health departments.

There is, too, an opportunity for closer liaison among all health agencies, official and voluntary. Some health departments appear to have an unreasonable fear of public interest and participation. A medical health officer of a western city asked at a public health meeting whether the community organizations might not attempt to take over a health program if encouraged to take part. The answer was that if this happened it would be the fault of the medical health officer, but that the probabilities were very slender. Most voluntary groups are willing to help, not to take responsibility for the activities of a department.

On the other hand there are some voluntary health associations which do not know how to work with official agencies, although this is mostly the result of unfortunate choice of spokesmen and personnel. A voluntary organization which proclaims itself as "God's gift to the people" and lets it appear that nothing ever happened before it arrived on the scene is not going to make friends among public health authorities.

The head of a national voluntary organization recently expressed the opinion that voluntary agencies were better able than governments to do health education. He may have had some particular situation in mind, but his assertion went from the particular to the general. It has been demonstrated that government, as represented by health departments, can do a most effective job of health education, with adequate resources, well-trained and excellently motivated staff.

Every voluntary organization is, by necessity, obliged to raise funds. Too often the fund-raising is a distasteful, time-consuming job to a program director who has no training or aptitude for it. Salaried staff are drawn into campaigns even when clever volunteer leadership is found. All this detracts from the efficiency and effectiveness of the voluntary association's program. Money-raising, certainly, has certain advantages. Both canvassers and contributors who might not have any other part in an agency's activities become involved in its general purposes.

There will probably be more rather than fewer voluntary health organizations on the Canadian scene in the near future. This might be a good time for existing agencies to do some frank self-analysis. Perhaps, too, there would be a good purpose served if an independent agency could make a detailed study of the existing national organizations with a view to suggesting ways in which they might strengthen their organizations and programs and be of greater service to the people of Canada.

The official health agencies, too, might well take a look at their relationships with the volunteers. It seems that in many places much closer liaisons could result in benefit to the official programs, and thus to the people for whose welfare they have been devised. There is in the departments not enough of the sentiment: "There is no limit to the amount of good a man can do so long as he doesn't care who gets the credit."

Program
**NINTH ANNUAL MEETING
OF THE
Ontario Public Health Association
KING EDWARD SHERATON HOTEL, TORONTO
SEPTEMBER 29, 30, OCTOBER 1, 1958**

MONDAY, SEPTEMBER 29, 8.30 a.m.

Registration, Mezzanine Foyer.

MONDAY, 9.30 a.m.

MINISTER'S CONFERENCE FOR MEDICAL OFFICERS OF HEALTH
(General Membership Welcome)
Crystal Ballroom

Presiding: W. G. BROWN, M.D., Deputy Minister of Health for Ontario.

9.30 a.m. **Address of Welcome.**

HON. MACKINNON PHILLIPS, M.D., Minister of Health for Ontario.

9.45 a.m. **New Legislation.**

MR. C. WALKER, Solicitor to the Department of Health for Ontario.

10.00 a.m. **Directors' Remarks and Discussion Period.**

11.00 a.m. **The Basic Principles of Atomic Energy.**

DAVID A. KEYS, PH.D., Consultant to the President, Atomic Energy of Canada, Limited, Chalk River.

MONDAY, 9.30 a.m.

PLUMBING INSPECTORS' SECTION

Elizabeth Room

Presiding: W. M. PRENTICE, P.ENG., Superintendent of Plant, Board of Education, Township of Scarborough.

9.30 a.m. **Section Business Meeting.**

10.00 a.m. **Sectional Participation in the Ontario Public Health Association: Its Implications for Plumbing Inspectors.**

GLENN T. MITTON, D.D.S., President, Ontario Public Health Association.

10.30 a.m. **Demonstration of New Products.**

MONDAY, 12.30 p.m.

LUNCHEON—GENERAL MEMBERSHIP

Sheraton Room

Presiding: GLENN T. MITTON, D.D.S., President, Ontario Public Health Association.

Address: **The Promise of Public Health.**

EDWARD G. McGAVRAN, M.D., Dean, School of Public Health, University of North Carolina, Chapel Hill, N.C.

MONDAY, 2.00 p.m.

MINISTER'S CONFERENCE FOR MEDICAL OFFICERS OF HEALTH
(General Membership Welcome)
Crystal Ballroom

Presiding: W. G. BROWN, M.D., Deputy Minister of Health for Ontario.

- 2.00 p.m. **Health and Safety in the Use of Atomic Energy.**
COLIN MAWSON, PH.D., Head, Environmental Research, Atomic Energy of Canada, Limited, Chalk River.
- 3.00 p.m. **The Challenge of Rabies.**
GARTH A. EDGE, D.V.M., Chief Veterinarian, Division of Environmental Sanitation, Ontario Department of Health.
- 3.30 p.m. **The Place of the Laboratory in Present-Day Public Health Practice.**
L. E. ELKERTON, M.D., Director, Division of Laboratory Services, Ontario Department of Health.

MONDAY, 2.00 p.m.

PLUMBING INSPECTORS' SECTION

Elizabeth Room

Presiding: H. F. BRADY, C.S.I.(C), Chief Plumbing Inspector, Board of Health, Township of Scarborough.

- 2.00 p.m. **Report of the Committee on Certification.**
W. M. PRENTICE, P.ENG., Chairman, Committee on Certification, Ontario Public Health Association.
- 2.40 p.m. **What is "Adequate" in Water Supply?**
K. M. ANTHONY, P.ENG., Public Utilities Commission, Township of Scarborough.
- 3.20 p.m. **Discussion of the Plumbing Code.**
Participants: VERNON BAKER, C.S.I.(C), Chief Plumbing Inspector, Department of Public Health, London.
FRED WHITEHEAD, Plumbing Inspector, Department of Public Health, Toronto.

MONDAY, 2.00 p.m.

VETERINARY PUBLIC HEALTH SECTION

Colonial Room

Presiding: G. C. FLEMING, D.V.M., Public Health Veterinarian, Department of Health, Hamilton.

- 2.00 p.m. **Paralytic Rabies.**
A. V. HALL, D.V.M., Veterinarian, Department of Health, London.
- 3.00 p.m. **The Role of the Public Health Veterinarian in the Event of a National Disaster.**
CHARLES A. MITCHELL, D.V.M., former Chief, Animal Diseases Research Institute, Canada Department of Agriculture.
- 4.00 p.m. **Section Business Meeting.**

MONDAY, 2.00 p.m.

ENVIRONMENTAL HYGIENE SECTION

Hunting Room

Presiding: L. W. HANCEY, C.S.I.(C), Sanitary Inspector, York County Health Unit.

- 2.00 p.m. **Section Business Meeting.**

MONDAY, 4.00 p.m.

HEALTH OFFICERS' SECTION

Crystal Ballroom

Presiding: A. H. BULL, M.D., Medical Officer of Health, Halton County Health Unit.

- 4.00 p.m. **Section Business Meeting.**

MONDAY, 4.00 p.m.
DENTAL PUBLIC HEALTH SECTION

Room 216

Presiding: F. H. COMPTON, D.D.S., Director, Division of Dental Services,
Department of Public Health, Toronto.

4.00 p.m. **Section Business Meeting.**

MONDAY, 4.00 p.m.
PUBLIC HEALTH NURSING SECTION

Canadian Court

Presiding: MISS H. E. FLETCHER, REG.N., Supervisor, Department of
Public Health, Toronto.

4.00 p.m. **Section Business Meeting.**

MONDAY, 4.00 p.m.
PUBLIC HEALTH EDUCATION SECTION

Room 215

Presiding: MISS M. CAHOON, B.ED., Associate in Public Health Education,
School of Hygiene, University of Toronto.

4.00 p.m. **Section Business Meeting.**

4.30 p.m. **Report from the Ontario Division of Health Information.**

K. L. HAWKINS, Director, Division of Health Information, Ontario
Department of Health.

MONDAY, 6.30 p.m.
NOMINATIONS AND RESOLUTIONS COMMITTEE
ONTARIO PUBLIC HEALTH ASSOCIATION

President's Suite

MONDAY, 7.30 p.m.
BOARD OF DIRECTORS
ONTARIO PUBLIC HEALTH ASSOCIATION

President's Suite

TUESDAY, SEPTEMBER 30, 8.30 a.m.

Registration, Mezzanine Foyer

TUESDAY, 9.00 a.m.
FIRST GENERAL SESSION

Crystal Ballroom

Chairman: W. G. BROWN, M.D., Deputy Minister of Health for Ontario.
Symposium: **Present-Day Problems in Public Health.**

9.00 a.m. **Changing Priorities in the Public Health Program.**

EDWARD G. McGAVRAN, M.D., Dean, School of Public Health, Uni-
versity of North Carolina, Chapel Hill, N.C.

9.25 a.m. **Air Pollution Control in Ontario.**

C. M. JEPHCOTT, PH.D., Director, Air Pollution Control Branch, Ontario
Department of Health.

9.50 a.m. **Integration and Conservation of Effort in Public Health Nursing.**

MISS DOROTHY PERCY, REG.N., Chief Nursing Consultant, Depart-
ment of National Health and Welfare, Ottawa.

10.15 a.m. **Food Additives.**

DR. L. I. PUGSLEY, Associate Director, Food and Drug Directorate,
Department of National Health and Welfare, Ottawa.

- 10.40 a.m. **Radiation and its Implications for Public Health Workers.**
E. A. WATKINSON, M.D., Principal Medical Officer, Environmental Health and Special Projects, Department of National Health and Welfare, Ottawa.
- 11.10 a.m. **Chairman's Remarks.**
W. G. BROWN, M.D., Deputy Minister of Health for Ontario.

TUESDAY, 11.30 a.m.

ANNUAL MEETING OF THE ONTARIO PUBLIC HEALTH ASSOCIATION

Crystal Ballroom

TUESDAY, 2.00 p.m.

HEALTH OFFICERS' SECTION

Mayfair Room

Presiding: COPE W. SCHWENGER, M.D., Medical Officer of Health, Dufferin County Health Unit.

- 2.00 p.m. **New Fields for Epidemiology.**
A. H. SELLERS, M.D., Director, Division of Medical Statistics and R. B. SUTHERLAND, M.D., Division of Industrial Hygiene, Ontario Department of Health.
- 3.00 p.m. **Trends in the Epidemiology and Treatment of Pulmonary Tuberculosis.**
C. A. WICKS, M.D., Superintendent, Toronto Hospital for Tuberculosis.

TUESDAY, 2.00 p.m.

PUBLIC HEALTH NURSING SECTION

Sheraton Room

Presiding: MISS EOLA SCOTT, REG.N., Director of Public Health Nursing, Simcoe County Health Unit.

- 2.00 p.m. **The Role of the Canadian Cancer Society in the Cancer Control Field.**
MR. MAURICE J. GRIMES, Executive Secretary, Ontario Division, Canadian Cancer Society, Toronto.
- 3.00 p.m. **The Need for Welfare Services by Cancer Patients.**
MISS MARION TRESIDDER, B.Sc.N., M.A., Administrative Assistant, Home Care Program, Department of Public Health.

TUESDAY, 2.00 p.m.

DENTAL PUBLIC HEALTH SECTION

Room 215

Presiding: F. H. COMPTON, D.D.S., Director, Division of Dental Services, Department of Public Health, Toronto.

- 2.00 p.m. **The Role of the Dentist in Civil Defence Health Services.**
HUGH R. McLAREN, D.D.S., Assistant Consultant, Dental Health Division, Department of National Health and Welfare, Ottawa.
- 3.00 p.m. **Caries Control.**
R. M. GRAINGER, D.D.S., Dental Statistics and Research Section, Division of Medical Statistics, Ontario Department of Health.

TUESDAY, 2.00 p.m.

VETERINARY PUBLIC HEALTH SECTION

Room 216

Presiding: A. V. HALL, D.V.M., Veterinarian, Department of Public Health, London.

- 2.00 p.m. **Viruses in the Udder.**
GEORGE BANNISTER, D.V.M., Veterinary Pathologist, Animal Diseases Research Institute, Canada Department of Agriculture, Hull, P.Q.

- 2.45 p.m. **Brucellosis Control Progress in Ontario.**
H. WORTON, D.V.M., Provincial Veterinarian, Ontario Department of Agriculture.
- 3.30 p.m. **The Role of the Public Health Veterinarian in Various Countries.**
L. W. McPHERSON, D.V.M., Associate Professor, Department of Microbiology, School of Hygiene, University of Toronto.

TUESDAY, 2.00 p.m.**ENVIRONMENTAL HYGIENE SECTION**

Room 219

Presiding: L. H. HANCEY, C.S.I.(C), Sanitary Inspector, York County Health Unit.

- 2.00 p.m. **Air Pollution in the Metro Area.**
HARRY BELYEA, P.ENG., Director, Metropolitan Air Pollution Control Division, Toronto.
- 3.00 p.m. **Panel Discussion: Integration of Urban and Rural Health Departments.**
Chairman: T. H. JACKSON, C.S.I.(C), Chief Quarantine Inspector, Department of Public Health, Toronto.
Participants: JACK FINLAYSON, C.S.I.(C), Chief Sanitary Inspector, Northumberland-Durham Health Unit.
ROBERT DOUBT, C.S.I.(C), Chief Sanitary Inspector, Simcoe County Health Unit.
THOMAS NEIL, C.S.I.(C), Supervisor, Division of Food Control, Department of Public Health, Toronto.
F. L. LUNN, C.S.I.(C), Secretary, Metropolitan Toronto and Region Conservation Authority, Woodbridge.

TUESDAY, 2.00 p.m.**PUBLIC HEALTH EDUCATION SECTION**

Room 225

Presiding: MISS ANNE GRANT, M.P.H., Health Education Consultant, Canadian Tuberculosis Association, Ottawa.

- 2.00 p.m. **Group Discussion: What is the Impact of Voluntary Agencies on Health Education in Ontario?**
Group Leader: ROBY KIDD, ED.D., Director, Canadian Association for Adult Education, Toronto.
- 3.30 p.m. **Report from the National Information Services.**
MR. HARVEY W. ADAMS, Information Services Division, Department of National Health and Welfare, Ottawa.

TUESDAY, 6.30 p.m.**PRESIDENT'S RECEPTION**

Reception Room

TUESDAY, 7.30 p.m.**ANNUAL DINNER AND PRESENTATION OF HONOURS**

Crystal Ballroom

Presiding: GLENN T. MITTON, D.D.S., President, Ontario Public Health Association.

Guest Speaker: MR. J. B. McGEACHY, Associate Editor, The Financial Post.

WEDNESDAY, OCTOBER 1, 9.30 a.m.**JOINT SECTION MEETING "A"**

(Public Health Nursing, Public Health Education, Dental Public Health)

Crystal Ballroom

Presiding: A. R. J. BOYD, M.D., Medical Officer of Health, Toronto.

- 9.30 a.m. **Visual Aids in Public Health Education:**
Introduction. MISS ANNE GRANT, M.P.H., Health Education Consultant,
Canadian Tuberculosis Association, Ottawa.
Demonstration. MISS MAY PALK, Director of Education, Victorian Order of
Nurses, Toronto.
- 11.00 a.m. **Future Public Health Uses of the Burlington Research Data in Respect to
Problems of Oral Health and Facial Development.**
FRANK POPOVICH, M.Sc.D., Director, Burlington Orthodontic Research
Centre, Burlington.

WEDNESDAY, 9.30 a.m.**JOINT SECTION MEETING "B"**

(Environmental Hygiene, Veterinary Public Health)
Hunting Room

Presiding: A. V. HALL, D.V.M., Veterinarian, Department of Health, London.

- 9.30 a.m. **The Provincial Program in Environmental Sanitation.**
MAX WALKINSHAW, P.ENG., Director, Division of Environmental
Sanitation, Ontario Department of Health.
- 10.20 a.m. **Interpretation of Ontario's Pesticides Act, and Review of New Products.**
W. L. SMITH, C.S.I.(C), Division of Industrial Hygiene, Ontario Depart-
ment of Health.
- 11.00 a.m. **The Relationship of Conservation to Public Health.**
F. L. LUNN, C.S.I.(C), Secretary, Metropolitan Toronto and Region
Conservation Authority, Woodbridge.

WEDNESDAY, 9.30 a.m.**HEALTH OFFICERS' SECTION**

Mayfair Room

Presiding L. A. CLARKE, M.D., Medical Officer of Health, Hamilton.

- 9.30 a.m. **Recent Advances in our Knowledge of Respiratory Infections of Interest to
Health Officers.**
A. J. RHODES, M.D., Director, School of Hygiene, University of Toronto.
- 11.00 a.m. **Joint Section Meeting "A"—Crystal Ballroom.**

WEDNESDAY, 2.00 p.m.**SECOND GENERAL SESSION**

Crystal Ballroom

Chairman: MILTON H. BROWN, M.D., Associate Director, School of Hygiene,
University of Toronto.

**Symposium: Public Health Implications of Recent Legislation in the Fields of
Hospital Insurance and Home Care.**

Participants

- K. C. CHARRON, M.D., Director of Health Services, Department of
National Health and Welfare, Ottawa.
R. W. I. URQUHART, M.D., Commissioner, Ontario Hospital Services
Commission, Toronto.
MISS LOUISE MINER, B.N., M.P.H., Public Health Nursing Supervisor,
Saskatchewan Department of Public Health, Regina.
CHARLOTTE HORNER, M.D., Medical Officer of Health, Northumber-
land-Durham Health Unit.
R. J. M. GALLOWAY, M.D., Special Committee on Medical Care and
Practice, Ontario Medical Association, Toronto.
L. A. PEQUEGNAT, M.D., Medical Director, Home Care Program,
Department of Public Health, Toronto.
D. G. GARDNER, B.A., M.S.W., Chief Supervisor of Homemakers and
Nurses Services, Ontario Department of Public Welfare, Toronto.

Canadian Journal of Public Health

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THE LABORATORY OF HYGIENE

THE creation of the Department of National Health in 1919 marked a new era in public health in Canada. Public health was represented in the Cabinet by the minister of health, the first member being the Honourable Newton W. Rowell with Dr. John A. Amyot as deputy minister. With the establishing of the department, the Food and Drug Laboratory, organized in 1884, was transferred to the department. In 1921, the Laboratory of Hygiene was organized under the direction of Dr. Norman MacLeod Harris. In the act establishing the department, special mention was made of research as one of its functions. It is significant that the first name of the Laboratory was the Division of Medical Research which was changed in 1925 to Laboratory of Hygiene. The Laboratory was established to inspect and control the manufacture of all chemical and biological products designed for injection into humans, to investigate diseases peculiar to Canada, to make investigations in industrial hygiene and to conduct research.

Dr. Harris was succeeded in 1939 by Dr. G. D. W. Cameron who continued as director until 1946 when he became director of health services and, subsequently, deputy minister. Under Dr. Cameron's direction, the work was extended to include standardization of diagnostic sera, control of antibiotics, certain special diagnostic services to the provinces and the beginning of virus studies. Dr. Cameron was succeeded by Dr. R. J. Gibbons who resigned after a short period to accept an appointment in the University of Ottawa. The present director, Mr. James Gibbard, M.Sc., succeeded Dr. Gibbons and under his leadership the work of the Laboratory has been further extended. To accommodate the work of the Laboratories in the field of virus infections, a virus laboratory was opened in 1954. The provision of this new unit of the Laboratory of Hygiene was most timely as it permitted the assumption of the highly important responsibilities relating to the testing and control of poliomyelitis vaccine (Salk) which was made available for national distribution in the following year. The contribution made by the Laboratory of Hygiene was of the greatest importance in the successful trial and use of this vaccine in Canada.

The Laboratory of Hygiene originally shared makeshift quarters with the Food and Drugs Laboratory and the National Film Board. In 1947, the

Laboratory moved to a war-time factory building in the west end of Ottawa. Plans for more adequate accommodation were made by Mr. Gibbard and his colleagues and a new building became a reality in 1957. A description of the new Laboratory is presented in this issue.

The Laboratory of Hygiene, with its separate virus laboratory, occupies a most important place in the program of public health in Canada. The services rendered to the provincial departments of health, to the medical and allied professions and to the public are of inestimable value. With the new facilities, research, including field investigations, can be extended and increasing contributions made in many important fields. Canada can well be proud of its Laboratory of Hygiene, its director and its staff.

IMPORTANT RESOLUTIONS

THE forty-sixth annual meeting of the Canadian Public Health Association brought together in Vancouver representatives of public health from all parts of the Dominion. The Association again endorsed the principle of prepaid health care services. It expressed its satisfaction with the early operation of the national Hospital Insurance and Diagnostic Services Plan in five provinces as part of an overall program for health services. The necessity was again stressed of close association of health departments in the planning and functioning of the program.

The Association gave consideration to the progress in Canada of the program of vaccination against poliomyelitis. It urged that efforts be made to ensure that all persons under 40 years of age receive the vaccine. It is estimated that 80 per cent or more of school children and pre-school children have received the vaccine but less than 20 per cent of those in the age group 15 to 40. There is great need for a Canada-wide program to enlist the older age groups in the vaccination program.

The Association again endorsed fluoridation of municipal water supplies as the only practical method of substantially reducing dental caries. The volume of evidence supporting this measure is now so great that its ultimate adoption is assured. Unfortunately, many communities are being deprived of its benefits through lack of information and the dissemination of misinformation. It is most important that the Canadian Public Health Association continue to affirm the value of fluoridation and to stress the great value of good teeth.

In considering the problem of accidental deaths the Association placed special emphasis on home accidents. It was urged that action be taken to inform the public of the present tragic situation and to assist in the development of preventive and educational programs.

For many years, the findings of study committees and the experience of public health leaders throughout Canada have been presented to the appropriate authorities in the form of resolutions passed at the annual meetings. These considered opinions have been appreciated and have contributed greatly to the advancement of public health in all the provinces.

Special Article:

THE NEW LABORATORY OF HYGIENE, OTTAWA

THE Laboratory of Hygiene of the Department of National Health and Welfare is now occupying its new main laboratory building located in Tunney's Pasture in the west end of Ottawa. Thus, after 36 years of temporary quarters, all branches of the Laboratory of Hygiene are now in a permanent location on the site chosen for all the buildings of the Department of National Health and Welfare.

The Laboratory of Hygiene was created in 1921, under the authority of an Act of Parliament passed in 1919. The original staff of two at that time occupied two rooms in an office building in downtown Ottawa. In 1931, the Laboratory moved to a converted lumber mill near the Ottawa river and, for the next 16 years, shared these makeshift quarters with the Food and Drugs Laboratory and the National Film Board. In 1947, the Laboratory was moved to a converted wartime factory in the west end of the city where it remained until the new buildings were completed.

In planning the permanent quarters of the Laboratory of Hygiene, every effort was made to combine functional design with flexibility. The Laboratory consists of a three-storey building approximately 250 × 140 feet, containing 163 rooms with a total floor area of approximately 70,000 square feet. It consists of two main wings—the laboratory wing at the front and an animal wing at the rear. These are joined at each end by two short sections to enclose an inner

court. This building plan provides future expansion at the south and west sides.

The inner construction of the building was designed to provide adequate working facilities for the diversified present and future programs of the Laboratory. Two independently-operated ventilation systems supply filtered, heated and washed air to the laboratories and animal quarters. To avoid dust-catching fixtures, the building is provided with radiant heating from panels in the ceiling of each room. In the design of the working laboratories, a fairly general pattern, consisting of 1- and 2-module units, was followed. The 1-module unit is approximately 10 feet wide by 20 feet deep and the 2-module unit is 20 feet wide with the same depth. Steel unitized furniture, interchangeable from room to room, is standard equipment in each laboratory. To provide for future changes in space requirements, the walls between each module are composed of movable steel partitions, designed for easy dismantling. Throughout the building, all services, including gas, electricity, water, distilled water and fume hood ventilation, are readily accessible from ducts located in the corridor leading into each module. In addition to the laboratories and animal quarters, a library, board and seminar room, administrative offices, filing room and typists' room are provided.

Administratively, the Laboratory of Hygiene is divided into seven sec-



New Laboratory of Hygiene, Ottawa

tions, with the chief of each section responsible to the Director of the Laboratory. These sections, at the present time are Administration, Bacteriology, Biochemical Research, Biologics Control, Clinical Chemistry, Zoonoses and Virology.

The Bacteriology Section, under Dr. E. T. Bynoe, is mainly concerned with diagnostic bacteriology and the preparation of standardized sera for use in provincial public health laboratories. In this section are located the National Enteric Bacteria Reference Centre and the National Reference Centre for the bacteriophage typing of staphylococci. In addition, studies are in progress on sanitary bacteriology, including a mobile laboratory for field work, and problems relating to hospital infections.

The Biochemical Research Section, under Dr. J. F. Morgan, is concerned with two main problems: (1) the nutrition and metabolism of tissue cultures of both normal and malignant origin and (2) studies on the separation, characterization and mode of action of bacterial toxins. Special facilities include two sterile rooms, two large biochemistry laboratories, and a

specially-equipped room for chromatography. In addition, laboratory space is provided for postdoctorate students.

The Biologics Control Section, under Dr. L. Greenberg, is responsible for the control of antibiotics, vaccines, and antisera used in Canada. Special facilities include a laboratory for isotope studies, a special room for pyrogen tests on rabbits, and sterile rooms. In addition to the control work, research is in progress on pertussis vaccine, typhoid vaccine and B.C.G.

The Clinical Chemistry Section, under Dr. R. H. Allen, is mainly concerned with standardization of laboratory procedures in use in hospitals and with serology, particularly syphilis serology. Special facilities of the section include a laboratory for work with inflammable materials, a room for the processing and drying of complement and a laboratory subdivided into four separate units for *Treponema Pallidum* Immobilization studies. The main studies in progress include investigation of clinical laboratory procedures and serological investigations.

The Zoonoses Section, under Dr.

J. A. McKiel, is concerned with animal pathogens transmissible to man. Special facilities of the section include sterile rooms and equipment for the preparation of antigens.

The Virus Section, under Dr. F. P. Nagler, has two main functions—(a) the assay of virus vaccines such as the Salk poliomyelitis vaccine and, (b) to serve as a reference centre for the identification of viruses and the preparation of diagnostic antigens. This section is housed in a separate building, approximately 100 yards away and was described previously in the Canadian Journal of Public Health (1).

The first Director of the Laboratory of Hygiene was Dr. Norman MacLeod Harris (1921–1938), followed successively by Dr. G. D. W. Cameron (1939–1946), Dr. R. J. Gibbons (1946–1947), and Mr. James Gibbard (1948–). The original Act of Parliament which created the Laboratory of Hygiene visualized the Laboratory as a reference centre for public health

work when in Section (b) it stated “The establishment and maintenance of a National Laboratory for Public Health and Research work”. The development of the Laboratory has paralleled the development of public health facilities in the country as a whole. This is exemplified by the progressive increase in staff from 2 in 1921 to 153 in 1958 and by the expansion of the Laboratory’s activities from bacteriology alone to include biologics control, biochemical research, clinical chemistry, virology and zoonoses. The location of the Laboratory in temporary and unsuitable quarters for much of its early period restricted many of the activities that could be undertaken. With the provision of a new laboratory building with adequate facilities for the first time, an expanded program of activity in the public health field has become possible.

1. *Canad. J. Pub. Health*: 1956, 47: 221.

The Canadian Public Health Association Annual Report 1957-1958

PART III

REPORT OF THE COMMITTEE ON RESOLUTIONS

M. R. ELLIOTT, M.D., D.P.H., Chairman

1. WHEREAS the hospitality shown to the delegates to this meeting has been warm and generous;
AND WHEREAS this has been made possible by the splendid co-operation of our joint hosts, the Province of British Columbia and the City of Vancouver;

BE IT RESOLVED that the Deputy Minister of Health of the Province of British Columbia and the Senior Medical Health Officer of the Metropolitan Health Committee of Greater Vancouver convey to their respective civic authorities the sincere thanks and appreciation of the Canadian Public Health Association for their generosity in making possible this very successful meeting.

BE IT FURTHER RESOLVED that the British Columbia Branch of the Canadian Public Health Association be commended for its part in the meeting.

2. WHEREAS the exhibitors have contributed greatly to the success and value of this meeting;
AND WHEREAS both the commercial and scientific exhibits have been of a uniformly high standard;
BE IT RESOLVED that the Canadian Public Health Association express its sincere appreciation of the contributions made by the exhibitors to the success of this meeting.
3. WHEREAS this combined meeting of the Western Branch of the American Public Health Association with the Canadian Public Health Association has been so successful;
AND WHEREAS the Western Branch has made such an outstanding contribution to the scientific program;
BE IT RESOLVED that the President of the Canadian Public Health Association communicate with the President of the Western Branch of the American Public Health Association in expressing our appreciation of this further demonstration of close collaboration in the field of public health.
4. WHEREAS the World Health Organization is commemorating its tenth anniversary;
AND WHEREAS the Canadian Public Health Association is keenly aware of the great work which this organization has accomplished in the field of international health;
BE IT RESOLVED that the President of the Canadian Public Health Association communicate with the Director General of the World Health Organization and extend congratulations of the Canadian Public Health Association to that Organization on its Tenth Anniversary and offer our best wishes for their future efforts in the betterment of health conditions throughout the world.
5. WHEREAS the Canadian Public Health Association has for many years endorsed the principle of prepaid health care services;
AND WHEREAS the Federal and Provincial governments are about to embark on a Hospital Insurance and Diagnostic Services Program;
AND WHEREAS this Association is convinced that there must be a close tie-in between public health and the Hospital Insurance and Diagnostic Services Program, with the realization that this is but an integral part of an overall program for health services;
BE IT RESOLVED that this Association reaffirm its support for health care

insurance, and stress the importance of Health Departments and Agencies playing a prominent role in this development.

6. WHEREAS evidence continues to accumulate that the administration of Polio Vaccine is a safe and effective procedure for the prevention of paralytic poliomyelitis;
AND WHEREAS this program has been extended in all provinces to include pre-school and school age children;
AND WHEREAS the greatest number of deaths from this disease now occur in the adult age group over 18 years;
BE IT RESOLVED that the Canadian Public Health Association endorse the administration of Polio Vaccine to all age groups up to at least 40 years, and urge that Health Departments encourage by all possible means the vaccination of the adult population.
7. WHEREAS there is continuing evidence that the controlled fluoridation of community water supplies is an effective agent in the reduction of dental caries in children;
AND WHEREAS it has been demonstrated that this controlled fluoridation of drinking water is a safe procedure;
AND WHEREAS the residents of many communities in Canada are still not receiving the benefits of this preventive measure;
AND WHEREAS the continuing shortage of dentists in Canada makes it imperative to adopt all possible preventive measures;
BE IT RESOLVED that the Canadian Public Health Association reaffirm its endorsement of the fluoridation of community water supplies as an effective and practical means of reducing the incidence of dental caries.
8. WHEREAS accidents constitute the leading cause of death at all ages from the second year of life to age 40, and account also for a considerable load of non-fatal morbidity and disability;
AND WHEREAS accidents occurring in the home have a particularly heavy effect at pre-school ages where other causes of death have shown considerable decline;
BE IT RESOLVED that the Canadian Public Health Association, its affiliated branches and the membership as a whole, take all possible action to inform the public of this tragic situation and assist with the development of preventive and educational programs.

NEWS NOTES

National

On October 7, 1957, a meeting of persons interested in nutrition research was held in Ottawa to discuss the formation of a nutrition society. A provisional committee was appointed to prepare a list of founding members and to draft a constitution. On June 8, 1958, a formal meeting took place in Queen's University, Kingston, Ontario. A membership of 90 was accepted, a constitution adopted, and the society was named the Nutrition Society of Canada. Membership is restricted to persons concerned with the scientific aspects of nutrition. Officers of the Society are: President, E. W. McHenry (Toronto); Vice-President, E. W. Crampton (Ste. Anne de Bellevue); Secretary, George H. Beaton (Toronto); Treasurer, J. A. Campbell (Ottawa); Councillors, D. H. Copp (Vancouver), W. W. Hawkins (Halifax), L. B. Pett (Ottawa). The Society plans to hold annual meetings.

Federal

Hon. J. Waldo Monteith, minister of National Health and Welfare, tabled in the House of Commons on July 9 copies of agreements between the Dominion government and the provinces of British Columbia, Alberta, Saskatchewan and Manitoba regarding contributions under the Hospital Insurance and Diagnostic Services Act.

The Civil Service Commission has approved the appointment of L. I. Pugsley, Ph.D., as associate director of the food and drug directorate, Department of National Health and Welfare. Succeeding Dr. Pugsley as assistant director (scientific services) is Ross A. Chapman, Ph.D., formerly head of the food chemistry section of the Ottawa laboratory.

A national health grant of more than \$21,000 has been awarded to the Notre Dame Hospital, Montreal, toward the cost of establishing a glaucoma clinic. This is the third such clinic to be established in Montreal with federal grants assistance.

Dr. N. J. B. Wiggin, formerly deputy chief superintendent of the Defence Research Board's chemical laboratories in Ottawa and in Kingston, Ont., has been named chief superintendent of DRB's medical laboratories at Downsview, near Toronto. He succeeds Dr. E. A. Sellers who has become head of the University of Toronto's department of pharmacology.

Miss Mary E. Acland has been appointed director of nursing for the Royal Ottawa Sanatorium, succeeding Miss Mabel M. Stewart, lady superintendent, who has retired after 33 years' service.

A national health grant of more than \$17,500 was recently allotted to the City of London, Ont., Health Department to assist with the cost of extending its public health services through the employment of additional personnel and the purchase of technical equipment.

Information Services Division, Department of National Health and Welfare, has recently issued a new catalogue of films and filmstrips as a guide to persons in health and welfare education. The division has also produced several new pamphlets, including two on accident prevention, *Keep Them Safe* and *How Safe is Your Home?*, and one entitled *Food Guide for the Older Person*.

The Dominion Bureau of Statistics stated that during 1957 the total number of families in Canada increased nearly 4% to 3,849,000 compared to 3,705,600 in 1956 and was more than 17% larger than the 1951 total of 3,282,400. The statistics for the average size family showed Newfoundland and New Brunswick leading with 4.5 persons. The smallest average was British Columbia with 3.4. Ontario's average was 3.5.

The Department of National Defence has appointed a full-time staff to work on a tri-service basis in the collection of data on work accidents. Under Captain J. S. Saull, the staff will undertake investigational, liaison and educational work to promote accident prevention activities among personnel of the Army, Navy and Air Force.

Dr. C. L. Francis of the Department of National Health and Welfare at Ottawa, has been appointed president of the Professional Institute of the Public Service of Canada.

M. Bruce McKenzie, M.S.W., consultant in medical social work in the medical rehabilitation and disability allowance service, was elected president of the Canadian Association of Social Workers at the biennial conference of the Association in Montreal early in June.

Newfoundland

The provincial government has announced during the past few months plans for capital

expenditures in health, education, road building and rural electrification. During the coming five years approximately \$20,000,000 will be spent in hospital and public health facilities. The projected hospital improvements include new hospitals, additions to existing hospitals and improvements to existing Cottage hospitals. A new nurses' residence will be erected in St. John's, alterations will be made to the regional laboratory on the west coast and new or improved physicians' residences will be provided in a number of centers. Studies made of the province's needs by 1963 show 3,000 general hospital beds and about 1,600 mental hospital beds. If the present plan is carried through there will still be a deficiency of about 600 general and 600 psychiatric beds to bring the accommodation to generally accepted standards.

Prince Edward Island

The Interprovincial Planning Committee on Health for the four Atlantic Provinces met in Charlottetown on July 28 and 29. Many topics concerning health in the Atlantic region were discussed with the main emphasis on hospital insurance. Representing Prince Edward Island were Dr. M. L. Bonnell, Dr. O. H. Curtis, Dr. B. D. Howatt, Dr. L. E. Prowse and Mr. C. Praught.

Mr. Harry Hodge has taken the position of chief physiotherapist at the Rehabilitation Centre. Mr. Hodge attended the Anderson College of Medicine in Glasgow and is a member of the Faculty for Physiotherapists of Scotland.

Mr. Garth C. Crockett, public health educator with the Provincial Department of Health, attended a three-week course in human relations and group development at Bethel, Maine.

Nova Scotia

The death of Dr. George H. Murphy at an age of 82 brings to an end a long life devoted to the best interests of his province and its people. A physician and teacher, he became Nova Scotia's first Minister of Health in 1930. During his tenure of office, he was responsible for many public health measures including the provision of the tuberculosis treatment and control program.

The official opening ceremonies of the new Dental Building at Dalhousie University will be held September 25 and 26. The occasion will be marked by a special convocation and a clinical program.

Miss Edna Walsh, R.N., B.Sc.N. Ed., has been appointed as consultant in the Child and Maternal Health Division.

New Brunswick

Hon. Dr. J. F. McNerney, minister of Health and Social Services, with chief medical officer, Dr. J. A. Melanson and director of health planning services, Dr. C. W. Kelly, have been engaged in a planned program of visits to every hospital in New Brunswick. The purpose of the visits is to discuss with hospital authorities the proposed hospital insurance plan as it relates to hospital administration.

Announcement has been made of a \$250,000 grant from the W. K. Kellogg Foundation to establish a nursing school at the University of New Brunswick. The grant will be extended over a period of eight years. The New Brunswick Association of Registered Nurses has been seeking the establishment of such a school since the recommendation for it was made in the "Russell Report on Nursing Education in New Brunswick".

Miss Katherine E. MacLaggan, formerly assistant director of public health nursing for the Department of Health and Social Services, has been appointed director of the University of New Brunswick School of Nursing. Miss MacLaggan joined the University in September and the first students will be admitted to the new school in September 1959.

Dr. J. C. Bourque has been appointed medical director for the new mental health clinic in Edmundston. Dr. Bourque will be assisted by Normand Clavet as psychiatric social worker and Miss Rachael Gagne as psychologist.

A third provincial regional laboratory will soon be in operation in New Brunswick at Campbellton. It is housed in one wing of the modern Provincial Hospital. Other regional laboratories are located at Fredericton and Moncton. The central Provincial Laboratory is located in Saint John.

Quebec

Premier Duplessis has announced that the provincial government will remodel the former St. Justin's Hospital in Montreal to provide facilities for the first of several diagnostic centers. The aim of the center is twofold; to enable sick persons with insufficient financial resources to obtain diagnostic services and to assist family physicians. This project has been under study for more than six years. In 1952, the legislature adopted legislation for the establishment of diagnosis centers. In 1956, \$8,000,000 was voted and at the last session an additional \$4,000,000 was provided. The center will not be administered by the

provincial government but will be conducted by a special body.

New provincial health regulations concerning communicable diseases are now effective. The regulations are presented in 15 sections and are most comprehensive.

Dr. Adrien Plouffe, assistant director of the Department of Health of Montreal retired after 29 years in the service of the city. As assistant director, he was attached to the office of the director and was responsible for the teaching of public health, contributing numerous articles to the press and medical publications in the province. He was elected a member of the Royal Society of Canada in 1948 and became president of the French-Canadian section in 1957.

Ontario

The first volume "Information Exchange for Health Officers" prepared by the Environmental Sanitation Division and the Public Health Information Division of the Ontario Department of Health has been distributed to medical officers of health and provincial sanitary inspectors.

An interesting trial of a plan for prepayment of medical prescriptions has been undertaken by the pharmacists of Windsor who have organized "Prescription Services Incorporated". The number of insured persons who will be accepted on a group basis is limited to 3,000. A survey will then be made which will extend over a period of 12 to 18 months.

Manitoba

The new Minister of Health and Public Welfare is Dr. George Johnson, M.D., a general practitioner from Gimli, Man. Only 37 years old, the new health minister obtained his B.Sc. from the University of Manitoba in 1941. He served during World War II with the Royal Canadian Navy, and following the war he entered medical college, graduating in 1950.

The Faculty of Medicine of the University of Manitoba, is celebrating its 75th anniversary, and will join with the Manitoba Medical Association, which is celebrating its 50th, at a special convocation October 6 to 10, to be held in Winnipeg. The convocation will feature prominent speakers from Canada, the U.S., England and the West Indies.

The Manitoba Power Commission, in cooperation with the provincial departments of health and agriculture, sponsored an exhibition of a modern plumbing installation in a farm home which was attended by over 200 persons. The Department of Health distributed pamphlets concerning septic

tanks, issuing of permits and other related subjects.

Saskatchewan

Miss Doreen E. Andrews, director, nutrition division, Department of Public Health and Mrs. Hester J. Kernen, assistant professor in public health nursing, School of Nursing, University of Saskatchewan, attended the twelfth Community Nutrition Institute at Syracuse University, Syracuse, N.Y. last June.

Three recent graduates of the University of Toronto School of Dental Hygiene have joined the Department of Public Health. Following a brief period of orientation in the department, Miss Margaret E. Andris will take up her duties in the Weyburn Health Region, Miss Donna J. Cathro in Moose Jaw and Miss E. Paulson in Prince Albert.

Dr. H. L. C. Young of Rothesay, Scotland, has been appointed assistant medical health officer of the North Battleford Health Region. Dr. Young obtained his degrees in medicine and surgery from the University of Glasgow in 1952 and his diploma in public health from the same university in 1957.

For some time, the Department of Public Health has been aware of the need for medical practitioners in small centers to have immediately accessible reliable blood sugar and blood urea results. To help meet this need, the Department, in conjunction with Regina College provided a course in elementary clinical chemistry from May 26 to June 6, 1958. Technicians attended from hospitals at Carrot River, Imperial, Indian Head, Kerrobert, Kyle, Langenburg, Lestock, Montmartre, Nokomis, Shaunavon, Theodore, Unity, Uranium City, Wadena, Wakaw, Wolseley and Wynyard. Procedures taught were cyanmethaemoglobin, blood sugars and blood ureas. Particular emphasis was placed on instruction in calibration and use of photoelectric colorimeters.

British Columbia

Two new community health centers have been opened recently, one at Vernon, which is the headquarters of the North Okanagan Health Unit, and another at West Summerland, which is in the South Okanagan Health Unit. This brings to 30 the number of community health centers which have been built since federal and provincial funds were made available to assist in construction.

The Victoria-Esquimalt Health Department recently announced the appointment of a new assistant medical health officer. Dr. John J. Glynn, formerly of Ireland and more recently of Montreal, took the position during August. Dr. Glynn received his D.P.H. from the University of Toronto.

Books and Reports

THE FIRST TEN YEARS OF THE WORLD HEALTH ORGANIZATION.

Published by the World Health Organization, Geneva. 1958, 538 pp. illustrated by 38 pages of photographs, \$5.00. Published also in French and Spanish editions.

WHO celebrated its tenth anniversary by holding a commemorative session of the General Assembly in Minneapolis preceding the eleventh session of the Assembly. To permit world-wide appreciation of the work which has been accomplished in the ten years, an anniversary publication covering the first ten years was prepared and published. In the foreword, Dr. M. G. Candau, Director General, states that his purpose was not only to review the history of the past ten years but also to place the events of that period against the background of previous achievements and to indicate the broad lines along which future activities could develop. The work of earlier health bodies such as the Office International d'Hygiène Publique and the Health Organization of the League of Nations were steps in the establishment of WHO. An explanation of the structure and working methods of WHO is presented and problems and programs of each of the six world regions are outlined. A major section of the book presents ten years of work under appropriate headings including malaria, tuberculosis, other communicable diseases, international quarantine, maternal and child health, pharmaceutical standards and nomenclature and other equally important work. The book is supplemented by a series of annexes containing useful background information. The interest of the volume is enhanced by several maps and charts and a number of pages of photographs.

The book is most interesting and readable and merits wide distribution. There has been a need for a comprehensive statement of the work of WHO. That need is met in this excellent publication.

TEN STEPS FORWARD, WORLD

HEALTH 1948-1958. *Dr. Brock Chisholm. Published by the Division of Public Information, World Health Organization, Geneva. 1957, 50 cents.*

Prepared with 24 pages of pictures and presented in a 68 page booklet, Dr. Brock Chisholm, first Director-General of the World Health Organization, records the achievements of WHO in the first ten years. For each year, Dr. Chisholm has selected the work in some particular field of public health. The publication is most attractive in its format and makes extensive use of photographs. From this most interesting account, everyone, familiar or not with public health, can appreciate the real meaning of the World Health Organization. Every public health worker should obtain a copy.

TEXTBOOK OF VIROLOGY. A. J. Rhodes, C. E. van Rooyen. William and Wilkins, Third edition. 1958, 642 pages, \$10.00.

The publication of the third edition is evidence of the appreciation of this excellent textbook in virology. Numerous advances in the field called for a major revision and the content has been increased from 565 pages to 642 pages. This textbook is concise and up-to-date and it is of great interest to undergraduate and postgraduate students as well as to clinicians. The two authors are internationally known for their studies in the virus field.

PUBLIC HEALTH AND SOCIAL SERVICES, D. H. Geffen, O.B.E., M.D., D.P.H., L. Farrer-Brown, B.Sc. (Econ.), and Michael D. Warren, M.D., D.P.H., D.I.H. Published in Canada by the Macmillan Co. of Canada Ltd., Toronto, Fourth Edition, 1957. 160 pp., \$1.50.

This is the fourth edition of a volume first published in 1940. The book was originally prepared as an elementary textbook for midwives, but its value has been appreciated by hospital nurses, social workers and home visitors. It accords an excellent introduction to public health and the social services. New chapters have been added including occupational health services and international health organizations. The authors have succeeded in making an admirable presentation of this subject.

